

**MEN'S PERCEPTION REGARDING VOLUNTARY CIRCUMCISION AT A MALE  
CLINIC, LESOTHO**

By

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## Dedication

*To my beautiful wife 'M'e 'Maboitumelo Moabi*

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## DECLARATION

I declare that **MEN'S PERCEPTION REGARDING VOLUNTARY CIRCUMCISION AT A MALE CLINIC, LESOTHO** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.



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07 June 2018

.....

**DATE**

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# **MEN'S PERCEPTION REGARDING VOLUNTARY CIRCUMCISION AT A MALE CLINIC, LESOTHO**

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## **ABSTRACT**

Medical male circumcision prevalence in Lesotho remains at 23% even though efforts are made to encourage men to be circumcised. The purpose of this study was to explore and describe perceptions of men regarding male circumcision in a hospital in Morija, Lesotho and make recommendations on how to promote uptake of medical male circumcision. A descriptive, explorative and contextual qualitative design was used. In-depth, unstructured individual interviews were conducted on ten (10) uncircumcised men who were selected via purposive sampling. The findings revealed that men's perceptions on circumcision can be classified under the following themes: perceived health beliefs of men about circumcision, perceived community-held beliefs about circumcision, men's knowledge regarding circumcision, and perceived misconceptions about circumcision. It is recommended that knowledge on circumcision be reinforced and negative perceptions be corrected with the multi-sectoral approach to promote uptake of circumcision services.

## **KEYWORDS**

Perceptions, voluntary medical male circumcision, male clinic and men

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## **LIST OF ABBREVIATIONS**

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARVs	Antiretroviral medications
BC	Before Christ
BCE	Before Common Era
DHS	Demographic Health Survey
HIV	Human Immune Deficiency Virus
IEC	Information Education Communication
ISRH	Integrated Sexual Reproductive Health
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency for AIDS Relief
PrEP	Pre-Exposure Prophylaxis
RCT	Randomised Controlled Trials
STIs	Sexually Transmitted Infections
UNAIDS	United Nation Program on HIV/AIDS
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organisation

# **CHAPTER 1**

## **OVERVIEW OF THE STUDY**

### **1.1 INTRODUCTION**

Voluntary Medical Male Circumcision (VMMC) refers to surgical removal of the foreskin of the penis by trained medical personnel in a hygienic setting (Tilly, Gurman, Dhillon, Jessica, Greene, Makadzange, Khumalo & Shekhar 2015:154). Maibvise and Mavundla (2015: Online) and PEPFAR (2011:3) explain that the aim of the removal of the foreskin is to reduce risk of Human Immune Deficiency Virus (HIV) transmission and susceptibility of men to other Sexually Transmitted Infections (STIs).

In 1982, in America, circumcision was done by physicians on new-borns routinely for hygienic purposes. This is supported by Maibvise and Mavundla (2015: Online) as they describe that circumcised babies are at a lower risk of developing urinary tract infections as opposed to uncircumcised ones because the foreskin which harbours various microorganism has been removed. Other physicians believed that circumcision reduces the risk of other cancers, thus conducted the procedure based on above-mentioned beliefs (Henerey 2004:271). On the contrary, some parents circumcised their children for cosmetic reasons. They wanted their children's penis to look more beautiful and to resemble other males.

Wilcken, Keil and Dick (2010: Online) are of the view that in Africa; male circumcision was initially carried out for cultural reasons. This procedure has been performed in a non-clinical setting by traditional doctors who have no formal training on medicine and surgery. Wilcken and colleagues also argue that this procedure is carried out as a rite to transition into manhood and it is mainly performed on adolescents and young men. Susman (2000) as cited by Mavundla, Netswera, Bottoman and Toth (2009:395), assert that circumcision in Africa has been done from long time ago although there is no documented evidence of such practice.

VMMC in Scott Hospital at Morija, Lesotho is done by Nurses and Doctors who are specifically trained to carry out such procedure. This procedure is done within the Scott

hospital in a department established for such a purpose. It is called “Males’ clinic”. Over and above VMMC, the department provides other services such as Intergrated Sexual Reproductive Health (ISRH) and Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) services to male clients.

Skolnik, Tsui, Ashengo, Kikaya and Lukobo-Durrell (2014:1) explain that voluntary medical male circumcision was initiated as a campaign in Lesotho in the year 2012. The aim was to circumcise as many males as possible and that resulted in having 42, 000 men between the ages of 15 to 29 years circumcised nationally by 2013. Lesotho being one of the countries with highest prevalence rates of HIV infection, the aim of the campaign was to contribute to its reduction.

The Ministry of Health Lesotho (2016a:ix) revealed that Lesotho is the third country with the highest prevalence of HIV in the world with an estimate of 23% of the total population. It is estimated that approximately 319, 000 people are living with HIV in Lesotho and 34% are women while 30% are men (Ministry of Health Lesotho 2016a:7). The guidelines further explain that 19,000 of people infected are children while 300, 000 are adults. The major route of transmission of HIV is sexual and VMMC can consequently play a major role in halting the spread. This view is supported by Morris, Hankins, Tobian, Krieger and Klausner (2014:[sp]) who maintain that male circumcision reduces chances of contracting STIs including HIV and AIDS.

Some people may have limited knowledge and different beliefs about circumcision which may influence their choice to be circumcised. It is the interest of the researcher to find out and explore perceptions of men regarding VMMC in a hospital in Morija, Lesotho.

## **1.2 BACKGROUND TO THE PROBLEM**

Henerey (2004:266) explains that the first record of male circumcision can be traced in the early years of King Ankh Manh, approximately 3000 Before Common Era (BCE). The removal of the foreskin was for social reasons. People wanted to be ranked on a high social class and as a result, they had to remove their foreskins. This is also evidenced in the Christian Bible where David brought 200 foreskins of Philistines to King Saul in exchange for rights to marry Saul’s daughter (2004:267).



Moreover, Henerey (2004:267) explains that, Jews carried out circumcision Before Christ (BC) for the following reason: Circumcision was regarded as a rite of passage to the Jew's culture. For one to be well integrated in the Jewish community, he had to be circumcised. Furthermore, the early Christians regarded circumcision as treatment of minor physical and mental illnesses. Some of the minor mental illnesses included masturbation and circumcision was believed to have remedial power (Henerey 2004:267).

In Lesotho, circumcision started even before 1820 where it was regarded as a transition to manhood. Young boys were taken to initiation schools to be taught about their culture and expected behaviours; and the traditional doctors were the ones performing circumcision (Walls 2014: Online). Even to date, circumcision is still conducted in the initiation schools. This ritual practice is also performed among Xhosa tribe in South Africa and it is also regarded as a transition to manhood as described in Mavundla, Netswera, Toth, Bottoman and Tenge (2010:1). Uncircumcised males are considered to be minors even if they are older than the circumcised ones.

In 2007, World Health Organisation (WHO) advocated for increase in VMMC in the 14 countries with high HIV prevalence. These countries included Botswana, Kenya, Lesotho, Republic of South Africa and Namibia (Morbidity and Mortality weekly report 2013:953). This publication states that approximately 1,020,424 males were circumcised from 2010 to 2012 in the nine countries with high prevalence of HIV as a result.

In Lesotho, Ministry of Health (2015:18) reports that the national target of VMMC was 250,000 for 2012 - 2016. But, only 100,000 males were circumcised at the end of 2015 and which shows that the country experienced challenges in meeting those set targets. Strategies need to be put in place to address the challenges of meeting the national targets. Aggressive efforts were made to train nurses and doctors regarding VMMC. The aim was to have the procedure performed in every health facility. Scott Hospital is not an exception in this regard. Results of Demographic Health survey 2014 showed that only 29% of men aged 15 to 24 have undergone VMMC. It is reported that 35% of men of similar ages were traditionally circumcised (Lesotho Ministry of Health 2016b:225).

### **1.3 STATEMENT OF THE PROBLEM**

The problem identified in this context is low medical circumcision rate, as Ministry of Health Lesotho (2016b:199) reports that circumcision prevalence is 23% in men aged between 14 to 49 years. In addition, results of Demographic Health survey conducted in Lesotho in 2014 showed that only 29% of men aged 15 to 24 have undergone medical circumcision. In terms of residence, 41% of medically circumcised men were from the urban areas while 13% were from rural areas. Scott Hospital is located in the urban areas of Lesotho in a district of Maseru, and 32% of the medically circumcised men are from Maseru district (Ministry of Health Lesotho 2016b:225).

HIV prevalence tends to increase in areas where there is low circumcision among men. This is because the major route of HIV transmission is unprotected sexual intercourse. VMMC is deemed to be part of the solution. In assessing information known by men regarding VMMC, a study was conducted in Lesotho in 2014 where 98 out of 161 participants (61%) explained that they learned about circumcision from friends who accessed VMMC service, while 29 out of 161 (18%) learned about circumcision from radio stations (Skolnik et al 2014:4). The question is how much knowledge men have on VMMC, much as they have heard about it. Men might have different understanding and perceptions regarding VMMC and that need to be explored.

Services of VMMC are still available and men are getting circumcised even if there is poor turn-up. The assumption could be men's beliefs and knowledge gap regarding VMMC, thereby affecting the prevalence of circumcision. It is for this study to determine men's perceptions on VMMC so as to make recommendations on how to address knowledge gaps on VMMC. Moreover, the spill-over effect may be to assist the country to reach out the national VMMC targets while trying to reduce HIV/AIDS prevalence within or amongst men.

#### **1.4 RESEARCH QUESTION**

The researcher observed that there is low circumcision prevalence in men, especially in Maseru district where Scott Hospital is located. In order to meet the objectives, the following research question guided this study:

- What are uncircumcised men perspectives on VMMC?

## **1.5 RESEARCH PURPOSE AND OBJECTIVES**

The main purpose of this study was to gain understanding of the perceptions of men regarding VMMC at a male clinic in a hospital in Morija, Lesotho.

For the researcher to achieve the above-mentioned purpose, the following objectives were formulated:

- To explore and describe the perceptions of men regarding VMMC in a hospital in Morija, Lesotho (Phase 1)
- To make relevant recommendations on how to promote the uptake of VMMC in general setting or context of this study (Phase 2)

## **1.6 SIGNIFICANCE OF THE STUDY**

The significance of this study is dealt with in terms of community, research, and legislation. These are detailed in the following discussions.

### **1.6.1 Community**

The study is likely to assist men to determine their perceptions regarding VMMC so that knowledge gaps on VMMC can be addressed. In addition, when males in the community are circumcised, this will reduce their chances of being infected with HIV and other STI's thereby reducing the incidence and prevalence of HIV in the community.

### **1.6.2 Research**

This study can act as a reference for future studies in areas pertaining to VMMC. In addition to that, the perceptions that the participants may have voiced out may serve as research questions for future studies.

### **1.6.3 Legislators**

The study may influence policy development on VMMC nationally. Policies which address knowledge gaps on VMMC can be drawn from the recommendations of this study. Legislators can use identified motivators to VMMC to attract more males to get circumcised, which will make it possible to meet the national VMMC target of 250,000.

## **1.7 PARADIGMATIC FOUNDATIONS OF THE STUDY**

Creswell (2014:36) explain that a paradigm is a basic set of beliefs that guide an action and it is sometimes referred to as “worldview”. Brink, Van der Walt and Van Rensburg (2012:24) describe a paradigm as a group of assumptions about basic kinds of entities in the world, how these entities interact and methods to be employed to test theories of these entities. Paradigms differ in the following ways: They differ on the nature of reality (ontologic), the relationship between the researcher and the participants (epistemologic) and the processes on how the inquirer obtains knowledge or best evidence (methodological). This study is grounded on constructivist paradigm and it is based on assumptions which are discussed in detail below: Ontological, epistemological and methodological assumptions.

### **1.7.1 Ontological (Meta-theoretical) Assumptions**

Van Rensburg (2010:18) explains that ontological assumption focuses on the nature of reality in a study. In constructivist paradigm, reality is multiple and subjective and it is mentally constructed by individuals (Polit & Beck 2012:13). In this study, the multiple and subjective reality of perceptions of men on VMMC were investigated and the aim was not to establish cause-effect relationship. The researcher used Maibvise and Mavundla (2018:9) model of promoting uptake of male circumcision as the theoretical framework. Maibvise and Mavundla (2018:9) explain the assumptions of the model that entail the following elements:

- A health related intervention is likely to be adopted if perceived benefits and/or the efficacy of the intervention outweighs perceived risks or barriers of adopting it.
- Men’s uptake of male circumcision depends on their individual perception of the procedure, and these perceptions can be modified or influenced, inter alia, by knowledge levels, demographic factors, and psychosocial factors.

- The low uptake of male circumcision is attributed to negative perceptions about the procedure, which are rooted in individual psycho-socio-cultural backgrounds or experiences, as well as misinformation and misconceptions about male circumcision.
- Harmonising the understanding of the meaning of the uptake of male circumcision in the context of HIV prevention helps to eliminate individual biases that may negatively influence men's perceptions and decision to undergo circumcision.
- Men's environment can be modelled to provide a more positive stimulus known as cues to action, or become more enabling, conducive and/or promotive of the uptake of male circumcision as a public health measure.

### **1.7.2 Epistemological (Theoretical) Assumptions**

This is the branch of philosophy that deals with the nature of knowledge (Van Rensburg 2010:19). Polit and Beck (2012:13) also explain that this assumption deals with the relationship of the researcher and those being studied. Constructivist paradigm allows the researcher to interact with those being studied. The researcher conducted in-depth unstructured individual interviews and the research findings are reflected or discussed within the parameters of the model to promote uptake of male circumcision as proposed by (Maibvise & Mavundla 2018:16). They further explain that the model serves as framework for health care providers to promote uptake of male circumcision and reduce transmission of HIV. Maibvise and Mavundla (2018.16) model of promoting uptake of male circumcision is dealt with in three steps, namely: (1) Influencing individual perceptions, (2) Facilitating access and utilisation of safe male circumcision and (3) Maintaining a supportive social support system services. These three intertwined steps which are building blocks of the model are discussed below.

#### **1.7.2.1 Step 1: Influencing individual perceptions**

Maibvise and Mavundla (2018.16) explain that individual's perceptions and knowledge play a major role in behavioural change. This implies that if an action is perceived positively and an individual is knowledgeable about it, he or she is likely to change behaviour. In this study, some participants explained that they are not circumcised because they do not know the importance of circumcision. Men need to be more

enlightened on circumcision and their negative perceptions be corrected so as to increase their motivation to be circumcised.

#### **1.7.2.2 Step 2: Facilitating access and utilisation of safe VMMC services**

Availability, accessibility and utilization of VMMC services must be ensured by the health care providers. These services must be accessible and affordable to all men in need. Men need to be made aware that only safe male circumcision services are provided in the clinical setting (Maibvise & Mavundla 2018:16). In this study, some men explained that they are not circumcised because they fear complications that may arise after the procedure. Men need to be informed that these complications can only be prevented and managed in a clinical setting through use of scientifically tested methods.

#### **1.7.2.3 Step 3: Maintaining a supportive social support system**

Health care providers (Nurses, Doctors, Midwives and Counsellors), uncircumcised men and social system need to interact in order to influence uncircumcised men to access circumcision (Maibvise & Mavundla 2018:16). Health care providers have to work hand in hand with men's social support system (relatives, spouses, community and spiritual leaders) to use men's positive perceptions to motivate men to be circumcised. The study shows that some men perceive circumcision as a passage to manhood and this positive perception can be used as a motivation.

#### **1.7.2.4 Definition of concepts**

For the purpose of this study, the following key concepts used in the study are defined as follows:

- **Voluntary Medical Male Circumcision (VMMC):** This is defined as surgical removal of the foreskin which is the tissue that covers the glans penis (Tilly et al 2015:154).
- **Men:** This refers to adult human male (English Oxford Dictionary 2017)

- **Perception:** English Oxford Dictionary (2017) explains perception as the way in which something is regarded, understood or interpreted.
- **Knowledge:** It refers to facts, information and skill acquired through education and experience (English Oxford Dictionary 2017).
- **Male clinic:** This refers to a hospital department that offers outpatient men medical treatment (English Oxford Dictionary 2017).

### 1.7.3 Methodological Assumptions

Polit and Beck (2012:13) explain that methodological assumptions deal with processes on how the inquirer obtains knowledge or best evidence. This study is founded on constructivist paradigm. According to same authors, there are two major paradigms which are positivist paradigm and constructivist paradigm. These two paradigms differ in ontology, epistemology and methodology (van Rensburg 2010:18). In constructivist paradigm, study participants develop varied and multiple subjective meaning of their experiences (Creswell 2014:37). Constructivist paradigm relies on participant's views of the situation being studied and questions asked must be broad and general so that participants can construct meaning of the situation. In this study, the broad question that is asked to the participants is "*What is your understanding regarding voluntary circumcision?*" This question allowed participants to express their various views on voluntary circumcision as this paradigm is rooted in multiple realities (Polit & Beck 2012:13).

With regard to a constructivist paradigm, the researcher interacts with the study participants. The above is evidenced by the fact that the researcher was interacting with study participants through in-depth unstructured individual interviews. No questionnaires were issued to the participants to complete. Data gathered on this paradigm cannot be manipulated statistically but meaning is constructed out of what the participants have said as this paradigm is grounded in participant's experiences (Polit & Beck 2012:13).

## **1.8 RESEARCH DESIGN**

In this study, the researcher used a qualitative design which is descriptive, explorative and contextual in nature and the study followed the following phases:

### **1.8.1 Phase 1: EXPLORATION AND DESCRIPTION OF PERCEPTIONS OF MEN REGARDING VMMC IN A HOSPITAL IN MORIJA, LESOTHO**

This is the phase where data was collected for the study. All ethical standards were maintained, the study population was identified and adequate sample was drawn from the specified population.

#### **1.8.1.1 Population**

Population comprised of uncircumcised men attending male clinic seeking other health services besides VMMC. Grove, Burns and Gray (2013:703) define population as elements which are individuals, objects, events or substances that meet the sample criteria in a study. This population will be fully discussed in chapter 3.

#### **1.8.1.2 Sampling technique**

After the population has been identified, sampling technique had to be chosen. The researcher used purposive sampling which is a type of nonprobability sampling approach. Brink et al (2012:139) explain that nonprobability sampling requires the researcher to select participants that are knowledgeable about subject at hand. The number of participants interviewed was determined by data saturation as described by Polit and Beck (2012:523). The researcher's inclusion criteria for the sample were as follows:

- Uncircumcised men attending males' clinic seeking other health services rather than VMMC.
- Be above 18 years
- Must be willing to participate in the study.
- Have to be able to speak Sesotho or English
- Must able to provide informed consent.



### **1.8.1.3 Data collection processes**

Data was collected by means of in-depth unstructured individual interviews and field notes. Potential participants were recruited while seating in the waiting room and data collection procedures were explained to them. Interviews were conducted in a private space in male clinic and the interviews were audio recorded so as they can be transcribed verbatim at the later stage. Participants were asked the following question:

**“What is your understanding regarding voluntary circumcision?”**

The participants were then offered an opportunity to reply to the central question and facilitative communications skills which include facilitative statements and facilitative questions as outlined by Mavundla, Poggenpoel and Gmeiner (2001:18) were utilised. These were used to ensure that the central question is adequately addressed.

Following Polit & Beck (2012:195), pilot interviews were done. These are small scale studies done before the major study to test feasibility of the proposed study and to assess appropriateness and quality of data collection instruments. Issues encountered during the pilot study were resolved.

### **1.8.1.4 Data analysis**

Data was analyzed following the eight steps of data analysis as spelt out by Tesch cited by Creswell (2014:248). Data analysis in this study was done concurrently with data collection (Brink et al 2012:193). This data analysis method is discussed in depth in chapter 3.

## **1.8.2 Phase 2: DEVELOPMENT OF RELEVANT RECOMMENDATIONS ON HOW TO PROMOTE THE UPTAKE OF VMMC AT A HOSPITAL IN MORIJA, LESOTHO.**

Collected data was used to develop recommendations on how to promote uptake of VMMC. Deductive reasoning was used to develop recommendations to promote uptake of VMMC and literature was reviewed to enhance the trustworthiness of the recommendations. These detailed recommendations are covered in chapter 5.

## **1.9 TRUSTWORTHINESS**

In order to ensure validity and reliability of the research, the researcher utilized trustworthiness criteria as recommended by Lincoln and Guba (1985) as well as Streubert & Carpenter (2011:316). Credibility, dependability, confirmability and transferability which are the four elements of trustworthiness were applied in this study. In order to ensure confidence in the truth of the data and their interpretations, the researcher applied the credibility criterion. To ensure reliability of data, the strategy of dependability was applied. In order to ensure objectivity where the findings are the results and experiences of the respondents not the preferences of the researcher, confirmability strategy was applied. To ensure extent to which the findings of the study can be applicable in other settings or groups, transferability criterion was considered (Polit & Beck 2012:584).

## **1.10 ETHICAL CONSIDERATIONS**

Before conducting the study, the researcher wrote request letters to Ministry of Health and Scott Hospital Medical Superintendent explaining the purpose of the study and how participants will be protected. Written permission letters were secured from both authorities. Permission was also obtained from men who volunteered to participate in the study and informed consent was given. Throughout the study, ethical principles were given due consideration and maintained. These are respect for person, informed consent, beneficence and justice.

## **1.11 SCOPE AND LIMITATIONS OF THE STUDY**

This study will be limited to assessing perceptions of men on VMMC at a hospital in Morija Lesotho. One can therefore not generalize the findings of the study as it is contextualized to a hospital in Morija Lesotho. Most of the participants were from urban areas and only a few were from rural areas. This underrepresentation of men from rural areas may affect quality of the data collected.

## **1.12 STRUCTURE OF THE DISSERTATION**

Chapter 1 introduced the study and outlined the research problem, aim, objectives and research design.

Chapter 2 discusses literature review

Chapter 3 discusses research design and methodology

Chapter 4 deals with discussion of findings and literature control

Chapter 5 deals with conclusions, limitations and recommendations

### **1.13 CONCLUSION**

This chapter described background, the problem that is being investigated, aims, paradigmatic foundation of the study and research design. The next chapter addresses literature review. Literature review is essential because it supports findings of a qualitative research study and also assists in comparing findings of existing studies to the one being conducted.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

This chapter presents a critical summary of literature on men's knowledge and perceptions regarding VMMC from various research studies. According to Brink et al (2012:71), the purpose of literature review is to support findings of a qualitative research study and also to compare findings of existing studies to the one being conducted.

This literature review focuses on areas as illustrated below. First, the history and rationale of male circumcision which provides more light on how and when male circumcision came around will be discussed. Second, regional male circumcision prevalence will also be discussed in depth in order to illustrate male circumcision trends. Third, perceptions and knowledge on VMMC will also be presented in detail. Lastly, global HIV trends, HIV situation in Lesotho and HIV prevention methods adopted in Lesotho will be dealt with.

#### **2.2 HISTORY AND RATIONALE OF MALE CIRCUMCISION**

The first record of removal of the foreskin can be traced in the early years of King Ankh Manh, approximately 3000 Before Common Era (BCE). Ankh Manh was the king of Egypt in 1333 BCE and it is during his ruling that foreskins were removed for social reasons. Males wanted to be ranked on a higher social class as a result; they had to remove their penile foreskins. In addition, removal of the foreskin is also evidenced in the Christian Bible where David brought 200 foreskins of Philistines to his King in exchange for rights to marry Saul's daughter, Michal (Henerey 2004:267).

Dunsmuir and Gordon (1999:1) assert that in ancient Egypt, circumcision served as a mark of slavery. Captured warriors were circumcised so as to degrade and humiliate them. In addition, all male descendants of the slaves were also circumcised and Jews were among the slaves. Later, Jews adopted and ritualised circumcision as it is explained in Genesis 17:10-14 that circumcision was a sign of pledge between God and his people and any uncircumcised man will be cut off from the community because he has broken the promise with God (Old Testament 2011:13). On the other hand, the early Christians regarded circumcision as treatment of minor physical and mental illnesses. Some of the

minor mental illnesses included masturbation where circumcision was believed to cause a decrease in masturbation (Henerey 2004:267).

Dunsmuir and Gordon (1999:4) contend that the first record of medical circumcision can be traced in the early 19<sup>th</sup> century in 1828 where circumcision was performed to treat a condition known as phimosis which is inability to retract the foreskin covering the glans penis. The procedure was performed by a surgeon using a blade to cut the tight foreskin without the use of anaesthesia. In the mid-19<sup>th</sup> century, surgical research evolved as aseptic technique and anaesthesia were introduced during circumcision. During that time, circumcision was believed to cure impotence, sterility and reduce chances for contracting venereal diseases (Dunsmuir & Gordon 1999:4).

During the early years in America, circumcision was done by physicians on new-borns routinely for hygienic purposes. Some doctors believed that circumcision reduces the risk of other cancers and conducted the procedure based on above believes (Henerey 2004:271). In contrary, some parents circumcised their children for cosmetic reasons. They wanted their children's penis to look more beautiful and to resemble other males (Henerey 2004:271).

In Africa, male circumcision was initially carried out for cultural reasons and this procedure was performed in a non-clinical setting by traditional doctors who have no formal training on medicine and surgery (Wilcken, Keil and Dick 2010: Online). Mavundla, Netswera, Bottoman and Toth (2009:395) explain that circumcision in Africa has been done from long time ago although there is no documented evidence to support that. This circumcision ritual is also performed in Xhosa tribe in South Africa and it is also regarded as a transition to manhood as described by Mavundla, Netswera, Toth, Bottoman and Tenge (2010:1). Uncircumcised males are considered to be minors even if they are older than the circumcised ones.

In the context of Lesotho, before 1820, young boys were taken to initiation schools to be taught about Basotho's culture and expected behaviours and traditional doctors were the ones doing circumcision (Walls 2014: Online). It is forbidden by customary law to divulge 'circumcision secrets' to those uncircumcised. As a punitive measure, those uncircumcised cannot be entrusted with national responsibilities. After introduction of Christianity in 1833, circumcision rates in Lesotho declined because youth had to acquire

life skills from schools and moral advice from churches (Molapo 1977:3). Currently, the situation is different as both traditional and medical male circumcisions are ongoing procedures. According to 2014 statistics, 29% of males aged 14 to 24 years were medically circumcised while 35% of them underwent traditional circumcision (Lesotho Ministry of Health 2016b:225). In this era, medical male circumcision has transited to be known as VMMC.

## **2.3 REGIONAL MALE CIRCUMCISION PREVALENCE**

Male circumcision is a global procedure for males done for various reasons and its prevalence differs according to regions. Globally, male circumcision which is currently referred to as VMMC is encouraged as a means of reducing HIV prevalence on the bases of three randomised controlled trials (RCT) conducted in South Africa, Uganda and Kenya (Nevin, Pfeiffer, Kibira, Lubinga, Mukose & Babigumira 2015:1). Currently, about 30% of males aged 15 and older are circumcised worldwide with majority (68.8%) being Muslims (WHO 2007:8).

### **2.3.1 North America, Europe, Central and South America**

In Europe and North America, circumcision was advocated as a preventive measure against masturbation, syphilis and penile cancer (WHO 2007:11). In United States of America, circumcision prevalence is estimated at 80% while in United Kingdom is 21%. WHO (2007:12) explain that circumcision is less common in Central and Southern America as in Colombia the prevalence is 11% while in Brazil is 7%.

### **2.3.2 Asia and Middle East**

Central Asia and Middle East has the highest circumcision rates as compared to Africa (WHO 2007:10). The high rates are attributed to the fact that circumcision is mainly done for religious reasons in Muslim countries and also as a routine in Republic of Korea and Philippines. The prevalence in Republic of Korea is 90%, while in Thailand is 70% (WHO 2007:10).

### **2.3.3 Africa**

WHO (2007:9) explain that circumcision is more prevalent in North and West Africa and less prevalent in Southern Africa. Circumcision prevalence in Kenya is 93%, Tanzania 84% while Rwanda is 70%. On the other hand, circumcision prevalence in South Africa is 35%, Botswana 13% and Lesotho 23%. The variations between North-West and Southern Africa are due to that fact that circumcision was abolished in Southern Africa by missionaries as it was regarded as an evil practice.

### **2.3.4 Lesotho**

In Lesotho's context, results of Demographic Health survey 2014 showed that on one hand, only 29% of men aged 15 to 24 have undergone medical circumcision. On the other hand, 35% of men of similar ages were traditionally circumcised (Lesotho Ministry of Health 2016b:225). The tables below show male circumcision prevalence in Lesotho in terms of age and residence.

**Table 2.1: Circumcision prevalence in Lesotho in terms of age**

Age	% of traditionally circumcised only	% of medically circumcised only	traditionally and medically circumcised	Number of men
15-24	35.4	29.0	5.3	1,252
15-19	25.6	30.0	3.2	691
20-24	47.3	27.8	7.9	561
25-29	51.8	18.8	5.9	410
30-39	52.0	18.8	3.6	610
40-49	54.8	15.1	2.0	389

(Lesotho Ministry of Health 2016b:255)

**Table 2.2 Circumcision prevalence in Lesotho in terms of residence**

Residence	% of traditionally circumcised only	% of medically circumcised only	% of both traditionally and medically circumcised	Number of men
Urban	22.1	41.3	5.0	920
Rural	56.5	13.4	4.3	1,741

(Lesotho Ministry of Health 2016b:255)

## 2.4 VOLUNTARY MEDICAL MALE CIRCUMCISION (VMMC)

VMMC refers to removal of the foreskin of the penis by trained medical personnel in a hygienic setting with the aim of reducing risk of HIV transmission and susceptibility of men to other STIs (Maibvise and Mavundla 2015:1) & (PEPFAR 2011:3).

In 2007, World Health Organisation (WHO) recommended VMMC as a comprehensive additional strategy for HIV prevention especially in areas where there is high HIV prevalence and low circumcision rates (WHO 2012: Online). This strategy was adopted and implemented in areas with high HIV prevalence and low circumcision rates. WHO (2012: Online) explain that VMMC reduces the chances of HIV from females to males by 60% and also other STI's. Moreover, VMMC saves cost by preventing new HIV infections hence reducing number of people needing antiretroviral treatment (ART).

Africa was not an exception as VMMC strategy was implemented in 14 countries with high HIV prevalence. The countries included Botswana, Kenya, Republic of South Africa, Namibia and Lesotho (Morbidity and Mortality weekly report 2013:953). Morbidity and Mortality weekly report (2013:953) reveals that approximately 1,020,424 males were circumcised from 2010 to 2012 in the nine countries with high prevalence of HIV.

Skolnik, Tsui, Ashengo, Kikaya and Lukobo-Durrell (2014:1) explain that VMMC was initiated as a campaign in Lesotho in the year 2012. The aim was to circumcise as many males as possible and at the end of 2013, 42, 000 men between the ages of 15 and 29 years were circumcised nationally. The significance of VMMC in Lesotho was that the country has the highest prevalence rates of HIV infection ranging second worldwide. The



campaign aimed at contributing to the reduction of HIV. The national target of VMMC was 250,000 from 2012 to 2016 but only 100,000 males were circumcised at the end of 2015. In order to meet the target, Nurses and Midwives are being trained on VMMC so that the procedure can be performed in every health facility (Lesotho Nursing Council 2016:13).

## **2.5 PERCEPTIONS ON VMMC**

Men and women have various perceptions regarding VMMC. Those perceptions have been identified from the literature in following areas: Fuelling the spread of HIV/AIDS, HIV and STI prevention strategy, improved penile hygiene, age at circumcision, painful procedure, tradition and masculinity, increased sexual pleasure, foreskin as important part of sex, exploitation, healing effects of vaginal secretions and procedure to be done in winter.

### **2.5.1 Fuelling spread of HIV/AIDS**

Some men and women have a belief that male circumcision fuels the spread of HIV. In China, from the study titled “attitudes towards male circumcision among Chinese and its implications”, some study participants believed that medical male circumcision is not the best strategy to combat HIV and circumcision may result in abusing sex practice where a man can have multiple sexual partners (Jia, Hawley & Zhang 2014:132). In the presence of multiple sexual partners, HIV can spread with ease from one infected partner to the uninfected one. This is supported by Naidoo, Dawood, Driver, Narainsamy, Ndlovu and Ndlovu (2012:Online) as they explain that from the study they conducted, some of the study participants regarded male circumcision as undermining existing protective behaviours and strategies. This implies that circumcised men may freely engage in unprotected sexual activities thinking that they are fully protected from HIV.

Nevin, Pfeiffer, Kibira, Lubinga, Mukose and Babigumira (2015:10) explain that some of their study participants were of the view that circumcision fuels the spread of HIV. This is because men have to resume sexual activity six (6) weeks post circumcision and their women are impatient and cannot wait for that long hence engages in sexual activities with other men. Moreover, Nevin et al (2015:10) argue that men who have under-gone circumcision are no longer satisfied with one or two partners but need multiple sexual partners. This tendency fuels the spread of HIV because HIV positive partner can transmit the virus to uninfected partners.

In Lesotho, the notion of VMMC fuelling the spread of HIV and encouraging promiscuity has been addressed by use of the media and positive messages on VMMC have been disseminated to the community (Public Eye 2017:19).

### **2.5.2 HIV/AIDS and STI prevention strategy**

Nevin et al (2015:10) establish that there is a clear relationship between male circumcision, HIV and STI's. Gasasira, Saker, Tsague, Nsanzimana, Gwiza, Mbabazi, Karema, Asiimwe and Mugweneza (2012: Online) explain that in Rwanda, 50% of the study participants were willing to get circumcised because they understood that circumcision prevents STI's and HIV. In addition, this is also supported by Peltzer (2013:5417) who conducted a study in South Africa where 40% of the respondents indicated that circumcision prevents STI's and HIV and this is supported by clinical trials conducted in South Africa, Uganda and Kenya (Nevin et al 2015:1).

The perception among men that one is fully protected from HIV while circumcised must be explored and proper education must be provided. Men need to be made aware that circumcision reduces chances of HIV transmission from an infected female partner to uninfected male partner by 60% as shown in the randomised controlled trials conducted in South Africa, Uganda and Kenya (Nevin et al 2015:1).

### **2.5.3 Improved penile hygiene**

Uncircumcised penis can harbour various microorganisms and dirt. This is made possible by the presence of foreskin which is a good medium for microbial growth. Gasasira et al (2012: Online) conducted a study in Rwanda which explored knowledge and perceptions of Rwandan men on male circumcision and to determine factors associated with willingness to be circumcised. Half of the respondents perceived circumcision as a good strategy of improving penile hygiene. This is because foreskin which harbours microbes and dirt has been removed.

Peltzer (2013:5417) and Macintyre, Andrinopoulos, Moses, Borstein, Ochieng, Peacock and Bertrand (2014:4) support the same belief as they explain that it is believed that men

carry a lot of dirt after sexual activity especially under their foreskin and circumcision can improve penile hygiene. This perception of improved penile hygiene must be emphasised during community outreaches as literature supports male circumcision as a strategy of improving penile hygiene.

#### **2.5.4 Age at circumcision**

Men can be medically circumcised at various stages of life: This can be during neonatal period, childhood, adolescence and adulthood. Circumcision is believed to be a procedure for young and sexually promiscuous men according to Gasasira et al (2012: Online) & Macintyre et al (2014:5). This is because older men believe that to them, circumcision can lead to bleeding and delayed wound healing due to their age. They believe that circumcision should be done to young energetic men because they are still active in sexual activities. This belief needs to be explored and corrected as this can act as a barrier to utilisation of VMMC services by older men.

#### **2.5.5 Pain-causing procedure**

After surgical removal of the foreskin, pain can occur because a surgical incision has been done. Some men especially under 19 years regarded circumcision as pain-causing procedure (Gasasira et al 2012: Online). Corduk, Unlu, Sarioglu-Buke, Buber, Savran and Zencir (2013:171) support this argument as they explain that 17% of their study participants explained that circumcision is very scary and painful and they will never repeat that procedure. Public eye (2017:17) also reports that herd boys in Lesotho fear to be circumcised because of fear of pain.

Pain is seen as a barrier in utilising male circumcision services as men feared pain caused by the procedure. Men need to be educated that before the foreskin is removed, a local anaesthetic is given to block pain and also post the procedure one is given analgesics to counteract the post-operative pain.

#### **2.5.6 Tradition and masculinity**

Some nations are traditionally circumcising while others do not. Macintyre et al (2014:3) explain that men over twenty five (25) years of age regarded circumcision as a tradition of some tribes and if they get circumcised, this implies that they are leaving their tradition

for a different one. This shows that male circumcision in other parts of Kenya is perceived as a tradition by which one identifies himself with a certain tribe. Corduk et al (2013:171) support the above-mentioned belief since they show that in Turkey, 30% of their study participants explained that they regard circumcision as a mission or obligation. This implies that it is man's duty to be circumcised because circumcision is part of their tradition.

Howard-Payne and Bowman (2017:70) conducted a study about the meaning of masculinity in perceptions of voluntary medical adult male circumcision for HIV prevention in South Africa. Howard-Payne & Bowman explain that study participants believed that men who are medically circumcised are more masculine than uncircumcised one. This is because it is believed that a real man must take right decision and be circumcised in order to protect loved ones from HIV infection.

### **2.5.7 Increased sexual pleasure**

There is a belief that there is a relationship between male circumcision, sexual pleasure and performance Gao et al (2015:1). Women aged 15-49 years in a study conducted by Maraux, Lissouba, Rain-Taljaard, Taljaard, Bouscailou, Lewis, Puren and Auvert in 2017 explain that they believe that circumcision increases pleasure during sex while 15% disagrees with that (Maraux et al 2017). This belief is also supported by a study conducted by Gao et al (2015:1) and Peltzer (2013:5417) who argue that circumcision increases men satisfaction during sexual intercourse. Increased sexual pleasure is attributed to the fact that the glans penis which is regarded as most sensitive is exposed during sexual activity.

Nevin et al (2015:10) describe that men and women from Uganda who participated in their study regarded circumcision as a surgical procedure that increases men's libido. This implies that men who have undergone circumcision are no longer satisfied by one or two partners but need multiple sexual partners. In addition to increased libido, Skolnik et al (2014:1) contend that men believe that VMMC enhances their sexual attractiveness and performance.

### **2.5.8 Foreskin as important part of sex**

Colombian men who have sex with other men have a various perceptions regarding the foreskin as described by Gonzales, Zea, Reisen, Bianchi, Rodriguez, Pardo and Poppen (2012:999). Men regarded a foreskin as an important part of sex and they prefer uncircumcised penis. This is because they prefer grabbing the foreskin, bringing it down and up (Gonzales et al 2012:999). Circumcision is also opposed by Jia et al (2014:132) who contest that male circumcision is regarded as an insane procedure because removing foreskin while there is nothing wrong with the penis shows people's minds do not work well.

### **2.5.9 Exploitation**

Some men in Uganda have a different perception regarding male circumcision. Nevin et al (2015:10) contend that some men explained that they cannot be circumcised because those foreskins are sold abroad. They believe that the foreskins are sold by government abroad and the foreskins are used to make women's creams. This perception shows that men do not trust health care providers. This issue needs to be clarified.

### **2.5.10 Healing effects of vaginal secretions**

Vaginal secretions are believed to play an important role in increasing healing rate of circumcision wounds. Nevin et al (2015:10) explain that, there is a belief that after a man has been circumcised, if he can have vaginal intercourse, the vaginal secretions will help the wound to dry quickly. This belief of healing effects of vaginal secretions needs to be corrected to the population as there is no literature that supports it.

### **2.5.11 Procedure to be done in winter**

Men have different beliefs on when to do circumcision as others prefer to do it during certain year seasons. Public eye (2017:17) explains that Basotho men prefer to be circumcised during winter because they belief that winter allows faster healing than summer. Messages need to be passed that every season is the right time to undergo circumcision as healing occurs naturally.

Despite all the above believes, the Ministry of Health Lesotho did by-in of the VMMC programme and that is why even to date it is still continuing in Lesotho. Skolnik et al (2014:1) explain that in Lesotho from February 2012 to December 2013, 42,000 men were circumcised in district hospitals while in Scott Hospital Morija, 1042 men were circumcised from January 2015 to March 2017.

## **2.6 KNOWLEDGE ON VMMC**

Knowledge determination regarding VMMC to all consent is very crucial, the reason why researches were conducted globally to assess men and women's knowledge regarding VMMC. Literature identified the following knowledge aspects: What is VMMC, who can conduct male circumcision and the importance of VMMC.

### **2.6.1 What is VMMC?**

Knowledge about VMMC and what it entails is crucial in determining whether one gets circumcised or not. Ikwegbue, Ross and Ogbonnaya (2015: Online) explain that in their study, 64% of the participants knew the meaning of voluntary medical male circumcision. This implies that the participants were only knowledgeable about the meaning of medical male circumcision as removal of the foreskin to promote penile hygiene and reduce risk of STIs transmission inclusive of HIV.

Peltzer (2013:5416) explains that in a study conducted in South Africa, results revealed that male circumcision knowledge was poor. The study reveals that 18% of the participants could provide correct answers about the procedure while 69% of the participants indicated that circumcision involves partial removal of the foreskin and 13% did not know about the procedure. Knowledge deficit should be addressed by providing health education to the communities through media.

### **2.6.2 Who can conduct male circumcision?**

Male circumcision must be done by a trained health care provider in a hygienic setting (PEPFAR 2011:3). A study conducted by Corduk et al (2012:171) shows that there is knowledge deficit regarding circumcision as study participants were not all knowledgeable about who should perform circumcision. The study revealed that 66% of

the participants were of the view that circumcision should be performed by a medical doctor while 17% indicated that circumcision can be performed by any health officer.

### **2.6.3 Importance of VMMC**

One of the importance of VMMC according to Lesotho Ministry of Health (2016a:4) and Skolnik et al (2014) is that VMMC is a good strategy of reducing HIV transmission by 60%. Mugwanya, Baeten, Nakku-Joloba, Katabira, Celum, Tisch and Whalen (2010:1192) argue that some of their study participants have knowledge about benefits of circumcision with respect to HIV. The study showed that 77% of men and 89.6% of women were knowledgeable that circumcision reduces risk of HIV-1 transmission to uninfected men and 95% of women were knowledgeable that circumcision does not offer full protection against HIV-1. In addition, more than 90% of participants had knowledge that circumcision of a man diagnosed with HIV-1 does not offer protection to HIV negative female partner.

In addition to that, Naidoo et al (2012:Online) also support the above notion as they explain that results of their study indicated that over 92% of the participants had knowledge that circumcision alone is not as effective as condom use in HIV prevention. The implication here is that even if a man is circumcised, he must still use a condom during sexual activity to prevent HIV transmission.

Going further, a study conducted by Jones, Cook, Arheart, Redding, Zulu, Castro and Weiss (2014:278) reveals that 10% of the participants did not have clear knowledge about circumcision as they said that circumcised men no longer need to use condoms during sexual intercourse as they are already protected from HIV. This shows lack of knowledge about circumcision on those study participants and positive messages need to be passed to the communities.

In conclusion, one would say that literature shows that some men are knowledgeable about VMMC while others have limited knowledge. Messages on VMMC must be tailored to meet specific needs of the community and all knowledge gaps must be addressed.

## **2.7 GLOBAL TRENDS OF HIV**

According to UNAIDS (2016:2), by the end of 2015 people who were living with HIV were 36.7 million while new HIV infections were 2.1 million globally. Prevalence of HIV in west and central Europe and North America by that time was 2.4 million while new infections were 91 000. The prevalence of HIV in eastern and Southern Africa by the end of 2015 was 19 million and new infections were 960 000. These statistics show that HIV is more prevalent in eastern and Southern Africa and these are the regions with low circumcision rates, and Sub-Saharan region has the most global infections of HIV of 25.6 million (70%) (Morbidity and mortality weekly report 2013:953).

HIV epidemic is a global concern and various strategies have been employed to address it. A 90-90-90 strategy has been employed by the global community and this implies that 90% of the total population must know their HIV status, 90% of those HIV positive must have access to HIV treatment (ARVs) and 90% of those on treatment must have suppressed viral load by 2030. In addition, various HIV prevention strategies have been implemented to curb the problem. These include use of condoms, VMMC, pre and post-exposure prophylaxis and women empowerment (UNAIDS 2016:11).

## **2.8 HIV SITUATION IN LESOTHO**

Lesotho, being one of the countries of the Sub-Sahara region, HIV prevalence by the end of 2014 was 25% as compared to 2009 when the prevalence was 23% (Lesotho Ministry of Health 2016b:235).

### **2.8.1 HIV/AIDS knowledge**

Lesotho Ministry of Health (2016b:205) explains that, more than 90% of the population which was under survey in 2014 have heard of the condition AIDS as depicted in the tables 2.3 and 2.4 below. This clearly shows that HIV related messages are passed to the population in order to inform communities. Urban communities though, are more informed than rural communities but generally, there is still high HIV prevalence rate in the country.



**Table 2.3: Knowledge of AIDS in Lesotho in terms of age**

Age	Women		Men	
	% who have heard of AIDS	Number of respondents	% who have heard of AIDS	Number of respondents
15-24	98.2	2,765	97.2	1,252
15-19	97.8	1,440	97.0	691
20-24	98.7	1,325	97.5	561
25-29	99.5	1,094	99.1	410
30-39	99.5	1,701	98.3	610
40-49	99.6	1,062	98.6	389

(Lesotho Ministry of Health 2016b:205)

**Table 2.4: Knowledge of AIDS in Lesotho in terms of residence**

Age	Women		Men	
	% who have heard of AIDS	Number of respondents	% who have heard of AIDS	Number of respondents
Urban	99.9	2,419	99.4	920
Rural	98.4	4,202	97.2	1,741

(Lesotho Ministry of Health 2016b:205)

### **2.8.2 HIV testing among men**

The Lesotho Ministry of Health (2016a:11) explains that HIV testing is the gateway to access of HIV care, treatment and prevention services. This is because HIV negative individuals will be linked to appropriate HIV prevention services while HIV positive individuals will be linked to early care and treatment services. In Lesotho, the results of the demographic health survey showed that 53% of men aged 15-24 years have been tested for HIV while 47% never got tested (Lesotho Ministry of Health 2016b:219). This

shows that high numbers of men have not tested for HIV and reasons for not being tested according the same ministry are fear of test results, stigma, death and fear of depression.

### **2.8.3 HIV prevalence by gender**

Lesotho Ministry of Health (2016b:235) continues to show that HIV prevalence is 30% in females and 19% in males. In addition, HIV incidence among men and women aged 15-49 is 1.9 new infections per 100 person-years. HIV prevalence in Lesotho in people aged 15-49 years is 25% according to Lesotho Ministry of Health (2016b:236). Arguing in the same vein, the prevalence is much higher in women as it is 30% as compared to men with 19%. Van Dyk (2012:39) explains that women are more likely to become infected with HIV during unprotected sexual intercourse because of their biological make-up. This is because during unprotected sexual intercourse, women are exposed to seminal fluid for longer time which has high concentration of HIV unlike men who are exposed to vaginal secretions for short period of time.

In addition to the biological make-up of women, social and cultural factors also increase the susceptibility of women to HIV. Van Dyk (2012:39) is of the view that unpowered women may not have a say on condom use during sexual activity with a partner. In some cultures, women must be submissive to men and as a result, an infected male partner can have unprotected sexual intercourse with uninfected female partner leading to the spread of HIV.

### **2.8.4 HIV prevalence on circumcised men**

The demographic health survey conducted in Lesotho in 2014 shows that HIV prevalence in men who have been medically circumcised is at 14% while in -uncircumcised men is 21% (Lesotho Ministry of Health 2016b:238). This is consistent with clinical trials conducted in South Africa, Kenya and Uganda which show that male circumcision reduces chances of female to male HIV infection by 60% (Nevin et al 2015:1).

### **2.8.5 HIV prevalence by sexual behaviours**

In Lesotho, the prevalence of HIV in men with concurrent and multiple sexual partners is at 27.4% according to the results of demographic health survey of 2014 (Lesotho Ministry

of Health 2016b:248). For men who had one sexual partner, HIV prevalence is at 21%. Van Dyk (2012:178) explains that concurrent and multiple sexual partners increase the risk of being infected with HIV. This is because one partner may be infected with HIV and through unprotected sexual intercourse; HIV may spread from the infected partner to the other.

Condom use also positively influences the spread of HIV. According to demographic health survey conducted in Lesotho in 2014, HIV prevalence is 22.1% in men who did not use condoms during sexual activities as compared to men who used condoms with the prevalence of 20.2%. Van Dyk (2012:166) is of the view that use of condoms reduces the incidence of HIV and other STIs. This is because the condom acts as a barrier to the virus, making it hard for the virus to gain entry to the host.

#### **2.8.6 HIV prevalence and sexually transmitted infections (STIs)**

Van Dyk (2012:40) explains that presence of sexually transmitted infections increases chances of being infected with HIV. Presence of STI's attracts CD4 cells and in return HIV infects those CD4 cells. In Lesotho, results of the demographic health survey show that 28.5% of men who are HIV positive had STI's in the past 12 months, while 19.3% did not have STIs. This shows that men with STI's are at risk of contracting HIV more as opposed to ones with no STIs.

### **2.9 HIV PREVENTION STRATEGIES ADOPTED IN LESOTHO**

In order to curb AIDS related deaths and new HIV infections, Lesotho adopted VMMC, test and treat strategy, pre-exposure prophylaxis and post-exposure prophylaxis (Lesotho Ministry of Health 2016a:i).

#### **2.9.1 Test and treat**

This is where all people diagnosed HIV positive are initiated on ARVs regardless of their CD4 count (Lesotho Ministry of Health 2016a:3). Treatment of HIV positive individuals with antiretroviral therapy (ART) leads to reduction of new HIV infections as people on ART with suppressed viral load are less infectious. Lesotho Ministry of Health (2016a:3) and Van Dyk (2012:57) explain that if an individual has suppressed viral load due to ART,

there are minimal chances of him/her transmitting the virus. Test and treat is a good strategy for halting the spread of HIV and eradicating the HIV epidemic.

### **2.9.2 Pre-exposure prophylaxis (PrEP)**

This refers to the use of antiretroviral medications (ARVs) in HIV negative individuals to reduce risk of being infected with HIV (Lesotho Ministry of Health 2016a:4). ARVs are given to people who are at risk of being infected with HIV and who are HIV negative. Risk assessment and HIV testing must be done before an individual is given PrEP. Priority for PrEP must be given to sex workers, men who have sex with other men, serodiscordant couples and people with multiple concurrent sexual partners (Lesotho Ministry of Health 2016a:4).

On the other hand, Van Dyk (2012:57) is of the view that PrEP has some challenges such as timing of initiating the drugs. This is because for PrEP to be effective, the drugs must be taken some hours before being exposed to HIV. In this case, an individual can sometimes engage in unplanned unprotected sexual intercourse and has not used the PrEP and that individual is likely to be infected with HIV.

### **2.9.3 Post-exposure prophylaxis (PEP)**

Lesotho Ministry of Health (2016a:5) explain PEP as activities taken after an individual has been exposed to HIV in order to prevent that individual from acquiring the HIV infection. These activities include first aid, counselling, HIV testing and initiation of ARVs for 28 days. The aim of PEP is to prevent HIV from invading testes and lymphatic system within 72 hours after the exposure. If the virus can invade the testes and lymphatic system, it will stay there permanently and PEP will not be effective (Lesotho Ministry of Health 2016a:5). Van Dyk (2012:127) debates that PEP medications must not be given to HIV infected people as this can increase chances of viral resistance to ARVs.

After an individual has been initiated on PEP medications, he or she must be given psychological support and be tested for HIV at six weeks post initiation, then at three months and lastly at six months post initiation (Lesotho Ministry of Health 2016a:9).

## **2.10 CONCLUSION**

This chapter presented different literatures on male circumcision and HIV. Male circumcision has been a procedure done for religious, social and medical reasons. In the fight against HIV epidemic, VMMC is regarded as a corner stone in reducing heterosexual HIV transmission as evidenced by the three randomised controlled trials conducted in South Africa, Uganda and Kenya (Nevin et al 2015:1). Results of the studies reviewed indicate that men have various perceptions and knowledge regarding VMMC. Some of the participants perceived VMMC as fuelling spread of HIV because circumcised men may not be satisfied by one sexual partner while others perceive circumcision as increasing pleasure during sexual intercourse. Some study participants are knowledgeable that male circumcision reduces the spread of HIV by 60% while others do not have the clear knowledge about VMMC as they said that circumcised men no longer need to use condoms during sexual intercourse as they are already protected from HIV. In Lesotho's context, VMMC is a priority HIV prevention strategy that is aimed at reducing new HIV infections (Lesotho Ministry of Health 2016a:4).

## **CHAPTER 3**

### **RESEARCH DESIGN AND METHODOLOGY**

#### **3.1 INTRODUCTION**

This chapter discusses research design and methodology used to explore and describe men's perceptions regarding voluntary circumcision so that proper recommendations can be made on how to promote uptake of male circumcision. A qualitative design is employed by the researcher to explore and describe the perceptions of men regarding VMMC within the context of a male circumcision clinic in Lesotho. For the researcher to gain more understanding of the phenomenon (perception of men) regarding the uptake of VMMC used various research methods. These include the selection of appropriate population and sampling technique, data gathering approaches, and application of relevant ethical principles and measures for ensuring trustworthiness in the study. The researcher discussed the methods used in this study in more detail in sections that follow.

#### **3.2 OBJECTIVES OF THE STUDY**

Polit and Beck (2012:73) describe objectives as specific accomplishments the researcher wants to achieve when conducting the study. This includes answering the research question by moving from step to step. In order for the researcher to reach the main purpose, which is to gain understanding of the perceptions of men regarding VMMC at a male clinic in a hospital in Morija Lesotho, the researcher formulated the following research objectives:

##### **3.2.1. Objective 1**

This objective is dealt with in chapter four of this study in this manner:

- To explore and describe the perceptions of men regarding VMMC in a hospital in Morija, Lesotho

### **3.2.2 Objective 2**

This objective is dealt with in chapter five of this study and it is addressed in the following manner:

- To make relevant recommendations on how to promote the uptake of VMMC in general and the setting or context of this study

These two objectives were achieved in this study by the use of relevant research design as discussed below:

## **3.3 RESEARCH DESIGN**

Polit and Beck (2012:73) are of the view that research design is an overall plan or architectural backbone for obtaining answers to research question. The research design guides the researcher in planning and implementing the study in a way to obtain valid results (Grove, Burns & Gray 2013:195). In this study, a qualitative, explorative, descriptive and contextual design was employed by the researcher and each aspect of it is discussed in detail below.

### **3.3.1 Qualitative aspect of research**

In this study, the researcher used a qualitative approach in order to gain insight on men's perceptions towards VMMC. Within the qualitative design, descriptive, exploratory and contextual aspects or characteristics of the design are followed.

Brink et al (2012:55) identify two research approaches which are qualitative and quantitative in nature. Qualitative research is defined as the process of studying observable facts in a holistic manner through collection of rich descriptive materials while quantitative research is the investigation of a phenomenon in a controlled setting through precise measurements (Polit & Beck 2012:739).

Polit and Beck (2012:488) explain that in qualitative research, data is collected in the real world where the researcher acts as a tool for data collection. The following are characteristics of qualitative research as cited by Brink et al (2012:212): The researcher

interacts with participants in their own language and setting. This indicates that data is collected in an environment where participants live and that environment is unstructured. Various data collection strategies are employed so that the strength of one method can complement weakness of the other. Interviews, observation and document analysis can be used to complement one another in qualitative research (Polit & Beck 2012:487).

This research design is flexible and non-sequential as emergent research design is given preference. Data collection techniques can change and the researcher needs to be accommodative to the changes. The aim of conducting qualitative research is to create an understanding of findings and not to generalize, unlike in quantitative research where the aim is to generalize the findings to the population (Grove et al 2013:24).

Joubert and Ehrlich (2007:318) are of the view that data collected consist of conversations, people or places and that information cannot be handled with statistical procedures. Thin and Remmelzwaal (2012:17) explain that qualitative research answer the research question starting with “why”. This implies that in qualitative research, researchers try to understand why people behave in a certain manner.

### **3.3.2 Exploratory aspect of design**

In conducting a qualitative study, it is always necessary for the researcher to explore in-depth the phenomenon being studied. Polit and Beck (2012:18) are of the view that explorative designs shed more light on phenomena that is little understood or that is relatively new in a given discipline. The full nature of the phenomenon, ways in which a phenomenon manifests and other factors related to it are investigated or brought to light. In this study, the researcher uses this aspect of the design to explore men’s perceptions regarding VMMC at a male clinic.

### **3.3.3 Descriptive aspect of design**

The researcher only described the perceptions of men regarding VMMC once they have been explored. Descriptive designs involve observation and describing phenomena as people experience it. Things that people experience include hearing, feeling, acting and believing. (Polit & Beck 2012:495). Grove et al (2013:215) explain that descriptive designs



can be used to develop theory, justify current practice and determine what others in similar situations are doing. In this design, variables are not manipulated because there is no intent of establishing causality.

Streubert and Carpenter (2011:81) discuss intuiting, analysing and describing as three essential steps in the descriptive design. These shall be discussed.

➤ Intuiting

This is where the researcher begins to be familiar with the experiences of the participants as described by the participants (Streubert & Carpenter 2011:81). The researcher has to avoid all criticism and opinions and pay attention to the phenomenon that is being investigated. To ensure intuiting, during the interviews the researcher was involved as a research instrument. He listened to individual perceptions on VMMC. During data transcription, data was studied and reviewed repeatedly on what were the perceptions of men on VMMC (Streubert & Carpenter 2011:81).

➤ Analyzing

Streubert and Carpenter (2011:81) are of the view that analysing involves “identifying the essence of the phenomenon under investigation based on data obtained and how the data are presented”. As the researcher listened to individual perceptions on VMMC, different themes, categories and subcategories emerged.

➤ Describing

Streubert and Carpenter (2011:82) explain that the aim of describing is to communicate and bring both written and verbal description based on classification or grouping of the phenomenon. It is important that researchers must avoid describing phenomenon prematurely. In this study, the researcher used this aspect of design to:

- Describe men’s perceptions regarding VMMC at a male clinic in Lesotho and
- Prescribe appropriate recommendations regarding the uptake of VMMC in a particular clinic in Lesotho.

### **3.3.4 Contextual aspect of design**

It is always necessary for a researcher to understand qualitative research within its context. Weissman (2014:[sp]) explain that contextual research design allows the researcher to investigate a phenomenon in the context where the participants live, work and play. Creswell (2014:243) is of the view that in order to ensure that studies are contextualized, data must be collected in the field where participants experience the issue under study and data collection instruments must not be sent to the participants to complete them. In addition the researcher must aim to describe and understand events within natural context in which they occur. The unique context used for the purpose of this study is male clinic where the participants were seeking medical services. At the end, the findings are presented in the context of the population studied which is “uncircumcised men at a male clinic in Lesotho”.

## **3.4 RESEARCH METHODOLOGY**

This study was conducted in two phases. The first dealt with exploration and description of perceptions of men regarding VMMC in a hospital in Morija Lesotho, Lesotho. The second one dealt with the development of relevant recommendations on how to promote the uptake of VMMC in general.

### **3.4.1 Phase 1: EXPLORATION AND DESCRIPTION OF PERCEPTIONS OF MEN REGARDING VMMC IN A HOSPITAL IN MORIJA, LESOTHO**

This is the phase where the researcher collected data for the study. The researcher ensured that all ethical standards were maintained, the population was identified and adequate sample was chosen from the specified population.

#### **3.4.1.1 Ethical considerations**

Ethics refers to moral principles that guide researcher’s behaviour or conduct (Streubert & Carpenter (2011:7). Brink et al (2012:32) explain that in order for the investigator to conduct research ethically, the following areas were considered: first, the research must

be done competently, rigorously, manage resources with integrity, acknowledge those who contributed fairly and consider the consequences of the research to the general population. Before conducting the study, the researcher wrote request letters to Ministry of Health and Scott Hospital Medical Superintendent explaining the purpose of the study and how will participants' rights be protected. Written permission letters were received from the two authorities. Permission was also obtained from men who volunteered to participate in the study and informed consent was given. Throughout the study, four ethical principles were maintained: respect for persons, informed consent, beneficence and justice.

### ➤ **Respect for persons**

According to Brink et al (2012:35), respect for persons entails the right that participants have to choose whether to participate in the study or not and those who have diminished autonomy are protected. Participants were informed on purpose of the study and they signed consent forms after they agreed to participate. The researcher did not use any form of coercion or punitive measures to the participants who did not want to participate in the study. Those who wanted to withdraw from the study were given freedom to do so.

### ➤ **Informed consent**

Informed consent refers to an ethical principle of ensuring voluntary participation in a study (Brink et al 2012:38). To ensure informed consent, the researcher ensured that all the participants were given the right information pertaining to this study, so they can exercise informed decisions whether to participate or not and their right to self-determination was protected. Consent forms were issued to all participants and for those who had challenge with literacy were guided on how to fill the consent forms. See annexure "H" for a consent form signed by participants in this study.

### ➤ **Principle of beneficence**

Beneficence means the participants' right to freedom from harm and exploitation and deals with the protection of the participants from any discomfort (Brink et al 2012:35). The researcher ensured that the study ran smoothly without any harm and minimized any risks by being sensitive when asking those questions that the participants may regard to

be invasive. The researcher ensured that they do not experience any discomfort and distress in their responses (non-verbal cues) and gave them the opportunity to ask questions. In addition, participants were informed that they have a right to terminate their participation at any point.

#### ➤ **Principle of justice**

Brink et al (2012:36) contends that justice entails participants' right to fair selection and treatment. This includes privacy where participants have the right to determine the extent to which their private information can be shared with the third party. Information relating to participant's attitudes, beliefs and opinions must not be shared without participant's consent. The researcher ensured participant's privacy by not sharing private information relating to the participants without their will.

This ethical principle also includes confidentiality where identity of study participants is only known by the researcher (Brink et al 2012:209). This implies that it is the researcher's responsibility to ensure that all gathered data cannot be linked to the individual participants. To ensure confidentiality, the researcher did not share the recordings of the interview with people not directly involved in the study and the participants were made aware of such.

Brink et al (2012:37) is of the view that anonymity entails making sure that participant's identities are kept secret with regard to their participation in a study. To ensure anonymity, each participant was identified by a code so as to enable them the freedom to voice out their submissions.

#### **3.4.1.2 Population**

Population is defined as elements which are individuals, objects, events or substances that meet the sample criteria in a study (Grove et al 2013:703). Brink et al (2012:131) describe target population as the entire set of elements which the researcher would like to make generalization. In this study, target population comprised of uncircumcised men attending male clinic seeking other health services rather than VMMC. Brink et al (2012:131) defines accessible population as portion of the population that is available for the research study and in this study it is comprised of uncircumcised males' clinic clients

seeking other health services rather than VMMC who were available during data collection and were willing to participate. Once the population was identified, a sample was chosen.

#### **3.4.1.3 Sampling criteria**

This is defined as attributes that participants have, that make them appropriate to be included or to be disqualified in a study and this concept has inclusion and exclusion criteria (Brink et al 2012:131). Inclusion criteria are characteristics that potential participants must have to be included in a study. To be included in the study, the participants had to meet the following inclusion criteria:

- Uncircumcised men attending males' clinic seeking other health services rather than VMMC.
- Be above 18 years
- Must be willing to participate in the study.
- Have to be able to speak Sesotho or English
- Must be able to provide informed consent.

#### **3.4.1.4 Sampling technique**

After sampling criteria has been defined, sampling technique to be used was identified. The researcher used purposive sampling which is a type of nonprobability sampling approach. Brink et al (2012:139) explains that nonprobability sampling requires the researcher to select participants that are knowledgeable about subject at hand. The researcher used this approach because the aim of the study is not to generalize the findings but to get deeper understanding of participants' views.

Purposive sampling refers to selecting participants that are knowledgeable about question at hand (Brink et al 2012:141). This selection is based on researchers' judgment regarding participants' knowledge on the subject under investigation. The researcher used this method because uncircumcised men attending males' clinic seeking other health services rather than VMMC had different perceptions on VMMC, thus why they are uncircumcised. In addition, due to the fact that it is difficult to draw a sampling frame from

this population, this sampling method was applicable. Sample size was unknown to the researcher and sampling continued until data saturation was reached (Polit & Beck 2012:523). That was the point where information collected became repetitive and same themes re-emerged.

#### **3.4.1.5 Data collection**

In this study, data was collected by means of in-depth unstructured individual interviews and field notes. Polit and Beck (2012:725) describe data collection as gathering information to address the research question. Sections to be included in data collection are type of data to be collected, process of data collection, the person to collect data, place where data will be collected, time when data will be collected and techniques that will be used to collect data (Brink et al. 2012:150).

##### ***3.4.1.5.1 Recruitment of participants***

Before interviews can be conducted, it is the duty of the researcher to recruit participants who meet eligibility criteria of the study. Masombuka (2013:54) explain that when recruiting study participants, it is the duty of the researcher to ensure that potential study participants are not forced to participate. Potential participants may be forced to participate by provision of incentives by the researcher, personal appeal of the researcher or even fear of consequences for not participating. Thin & Remmelzwaal (2012:4) explain that potential participants must have the capacity or authority to participate, be given all information pertaining to the study and they must choose at free will to participate and withdraw from the study at any time.

On week days before the routine of male clinic commences, health education is given by the clinic staff to the clients who are seated in the waiting area. After a health education session while the clients are still seated in the waiting area, the researcher explained the purpose of research to potential participants and addressed issues of confidentiality. The criteria for inclusion and issues relating to informed consent were also shared. Furthermore, data collection by a means of an interview lasting approximately thirty to forty five minutes (30-45) was addressed. Potential participants were informed that they

may be interviewed immediately after being attended by a health care provider and or while waiting for the services in a private space.

Polit and Beck (2012:543) are of the view that immediately after an interview, tape-recorded interviews should be listened to, checked for completeness and be transcribed verbatim. Potential participants were informed that only two interviews will be conducted per day to allow the researcher time to understand and reflect on the conducted interviews. Finally, interested participants could meet the researcher in order to agree on time convenient to them to conduct the interview.

#### ***3.4.1.5.2 In-depth face-to-face unstructured individual Interviews***

In this study, in-depth face-to-face unstructured individual interviews were conducted because the researcher wanted to collect qualitative data and give participants chance to ask questions where they did not understand. In addition to that, in-depth face-to-face unstructured individual interviews allowed participants to tell their stories with minimal interruptions. Moreover, this type of interview allowed the researcher to pose probing questions when there was limited understanding between the researcher and the participants or when minimal verbal responses ensured.

Grove et al (2013:270) explain an interview as an interaction between research participant and the researcher who aims to produce data in forms of words. According to van Rensburg (2010:179), an interview can be in the form of face-to-face contact or telephonic. Conducting interviews is advantageous in that interviews provide a leeway for more clarifications. Furthermore, additional information can be obtained by asking follow-up questions and non-verbal cues are noted. However, interviews can be disadvantageous because bias can occur where the participant may refrain from providing factual personal information because of differences in personal characteristics (age, race and gender) between the researcher and the participant. In addition, interviews are costly because the researcher needs to travel to the participants to collect data (van Rensburg 2010:184).

According to Polit and Beck (2012:357), interviews can be conducted on individuals or groups. With individual interviews, discussion is only between the researcher and the participant while in focused group, the researcher interviews five or more participants at

one time in a group. Generally, interviews are classified into three, namely: structured, semi-structured and unstructured interviews (Brink et al 2012:158). In structured interviews, all respondents are asked the same questions in the same manner and order. The aim is to obtain clear and factual information. Semi-structured interviews allow the researcher to cover specific set of topics during the interview. The researcher prepares a list of questions to be answered and encourage respondents to freely tell their stories. On the other hand, unstructured interviews allow free flowing of discussion between the researcher and the respondent. These interviews allow participants to tell their stories with little interruption from the researcher. The researcher may start the interview with a broad opening statement and allow the respondent to tell his/her story (Brink et al. 2012:158), (Polit & Beck 2012:356) & (Grove et al 2013:271).

#### ***3.4.1.5.3 Conducting an interview***

As discussed that the interviews were conducted in a private space at male clinic, the participants were seated face to face with the researcher after an appointment had been set. The researcher reintroduced himself and explained what the purpose of this study was. Also, that participation in this study is voluntary and participants can withdraw at any time of the study without consequences. Voluntarism is explained by Thin and Remmelzwaal (2012:4) as the right that participants have on choosing whether to participate in a study or not.

Participants were also informed that the contents of data collected will be discussed with the study supervisor and research findings may be published in one of the academic journals. In order to ensure anonymity, it was further explained that study participants will be identified by codes not real names so that they cannot be linked to the contents of the data. Thin and Remmelzwaal (2012:5) are of the view that all study participants have a right that, information given to the researcher may not be linked to them during the study or when the results are published.

Since the interviews were digitally recorded, it was essential to seek their consent. Polit and Beck (2012:534) explain that recording an interview ensures that data is participants' actual verbatim responses and allows the researcher to give the participant full attention during the interview. Recording of an interview also allows the researcher not to misinterpret what the participant has said during data analysis as described by Van



Rensburg (2010:183). The recorder was placed in such a way that it does not disrupt the interview but captures the whole process.

Following interactions, participants were then given a document disclosing all information that has been discussed. This is the letter that also has an informed consent form attached. Participants could read and understand. Then, the participants were given time to make a decision on whether to participate or not and were also given chance to ask questions. Polit and Beck (2012:159) are of the view that this written notice should never take the place of the spoken explanations because spoken explanations give chance for elaborations and question asking.

Once the participants agreed to take part in the study, the researcher then asked them to sign the consent form that shows that he is participating voluntarily and understands study goals, type of data to be collected, confidentiality pledge and the nature of the commitment as described by Polit and Beck (2012:158).

When commencing with the interview, the participants were given participation codes as a method of identification and the participants were made aware that the audio recording of the interview had commenced. Following this, participants were asked questions regarding demography: Age, marital status, religion, residence, level of education and employment status. These questions assisted the interviewer and the participants to relax, and also build a good rapport as explained by Polit and Beck (2012:542) & (Grove et al. 2013:272).

Prior to the main question, the participants were afforded an opportunity to ask questions if they have any. They were then explained that as discussed earlier, we are here to share your perceptions on voluntary circumcision and sharing your experience will be based on the following central question: *“What is your understanding regarding voluntary circumcision?”* Then the participants were offered an opportunity to reply to the central question.

At the end of the interview, the researcher asked adopted a question as quoted from Polit and Beck (2012:543); *“are there any questions that you think I should have asked you?”* This question ensured a positive closure of the interview and the participants were complemented for their efforts.

#### **3.4.1.5.4 Facilitative communication skills**

In order to ensure that the central question is adequately addressed during the interview, the researcher used facilitative communications skills which include facilitative statements and facilitative questions as outlined by Mavundla et al (2001:18).

Facilitative communication is defined as a process where a researcher assists the participant to open up and express self (Mavundla et al 2001:18) & (Maibvise 2012:60). These statements encouraged men to freely voice out their perceptions on voluntary circumcision. The following are some facilitative statements which were used depending on participant's response:

#### **Facilitative statements**

- Reflecting the content: Skills you need (2018:online) explains reflecting the content as restating what the other person has said with the aim of allowing the speaker to hear their content and focus on what they have said. This also allows the speaker to continue talking. When reflecting the content, the researcher repeated participant's basic statements in order to provide the participant with a chance to listen and think of what he has said.
- Questioning: This refers to a process where information is gathered by asking more questions on discussed phenomena. The aim of questioning is to gain information, help maintain control of the conversation, clarify a point and express an interest in the other person (Skills you need 2018: online). When using questioning as a facilitative statement, the researcher questioned the participant to clarify what he said.
- Clarifying: Maibvise (2012:61) explains clarifying as a phenomenon where information is made to be understood with ease. The purpose of clarifying is to ensure that the listener understand what the speaker has said. During clarifying, when the researcher did not understand what the participant has said, the researcher asked questions or summarized what the participant had said.

- Paraphrasing: Mavundla et al (2001:18) & McNamara (2012: online) describes paraphrasing as repeating participant's verbal statement with own words to ensure understanding. The listener attempts to understand what the speaker is saying. In this study, when researcher did not understand what the participant has said, the researcher repeated participant's verbal statement with own words to ensure understanding.
- Probing: Polit and Beck (2012:738) describe probing as eliciting detailed useful information from participants in an interview that was volunteered. According to Maibvise (2012:61) probing triggers additional thoughts hence providing more detailed information. Probing is essential when the participant provide minimal verbal responses. Minimal verbal responses may include giving of short answers by the participant or the participant indicating that he does not know (Grove et al 2013:272 & 424). The researcher encouraged participants to elaborate further using nonthreatening but thought provoking questions. The researcher probed in a manner that he did not lead participant's responses or participant felt like he is being cross-examined (Grove et al 2013:424).

During the interviews, the researcher listened actively to participant's responses, maintained eye contact and used non-verbal cues such as nodding, smiling, and raising the eyebrows to show that he is interested to what the participants were saying (Grove et al 2013:272).

#### **3.4.1.5.5 Field notes**

During the interviews, hand-written notes were recorded by the researcher as part of observations of non-verbal cues. Polit and Beck (2012:728) define field notes as the recordings and interpretations of unstructured observations by the researcher while in the field. Maibvise (2012:62) explain that these notes are jotted down and aid in recalling of observations done during an interview. University of Southern California (2018: online) explain that field notes must be accurate, organized, descriptive, focus on the research question and record insights and thoughts. According to Polit and Beck (2012:548), field notes are categorized into two, mainly observational and reflective notes.

- **Observational (descriptive) notes:** These are objective descriptions about observed events, and conversations (Polit & Beck 2012:548). These include “how the situation was during data collection, who was involved, what was done, how were participants’ facial reactions when asked questions”. The physical environment, setting, date and time when data was collected must also be included in these notes (University of Southern California 2018: online).
- **Reflective notes:** Polit and Beck (2012:549) are of the view that these notes encompass researcher’s personal experiences, feelings, ideas, reflections and thoughts. These notes according to University of Southern California (2018: online) assist the researcher to clarify his thoughts and experiences during data collection. These notes need to be analysed as they are documented because they foster self-reflection which is important in understanding the research study (University of Southern California 2018: online). The following are types of reflective notes jotted while in the field:

**Methodological notes:** Polit and Beck (2012:549) are of the view that methodological notes contain reflections about interviews conducted. These notes assisted the researcher as they acted as reminders about how subsequent interviews will be conducted. This is because the notes assist the researcher to improve his interviewing skills and alter the initially planned interview technique.

**Personal notes:** These refer to comments about the researcher’s own feelings in the field (Polit & Beck 2012:549). These personal feelings can influence what is being observed and the researcher reflected on challenges and emotions experienced during data collection. If the researcher does not reflect on his personal feelings, this can influence study results hence affecting integrity of the study.

**Theoretical notes:** According to Polit and Beck (2012:549), theoretical notes are reflections about researcher’s thoughts on how to make meaning to what is being observed. These notes served as starting point for subsequent data analysis.

#### **3.4.1.6 Pilot interviews**

The researcher conducted pilot interviews with three (3) participants. These participants provided relevant responses and their information form part of the main study. These pilot interviews were done to test feasibility of the study and to assess appropriateness and quality of data collection instruments (Polit & Beck 2012:195). Pilot study is a small scale study done before the major study. It is done on a small number of the participants from the population at hand (Brink et al 2012:174).

#### **3.4.1.7 Data analysis**

In order to conduct a complete and comprehensive data analysis, the recordings from audiotape recorder were transcribed verbatim and analysis was performed following the eight steps of data analysis as spelt out by Tesch cited by Creswell (2014:248). Data analysis in this study was done concurrently with data collection (Brink et al 2012:193).

Polit and Beck (2012:724) defines data analysis as systematic organisation and synthesis of research data. This implies that collected data is brought into order and meaning is extracted out of that data and invisibles are made obvious. In qualitative studies, data analysis is time consuming as text collected needs a thorough and proper examination.

The following eight steps of data analysis as spelt out by Tesch were employed:

- Get the sense of the whole: The researcher read all transcriptions carefully and jotted down ideas that came to his mind.
- Pick one document: The researcher picked most interesting and short document, went through it and asked himself on “what the document is about”. He did not think about the substance of the information but thought of the underlying meaning.
- Make a list of topics: After the researcher had gone through documents of various participants, he clustered similar topics together. The topics were put in columns and arranged as major, unique topics and leftovers.
- Taking the list: The list was taken back to the data and topics were abbreviated as codes and the codes were written next to the appropriate segment of the text. The preliminary organizing scheme was executed to assess if new categories and codes emerge.

- Finding most descriptive wording: The researcher found most descriptive wording and turned them into categories. The total list was reduced by grouping topics that relate to one another.
- Make final decision on the abbreviations: The researcher made final decision on the abbreviations for each category and alphabetized the codes.
- Assembling data material: Data material belonging to each category was assembled in one place and preliminary analysis was performed.
- Recode existing data: When necessary, the researcher recoded existing data.

#### **3.4.1.8 Literature control**

Literature review is explained by Brink et al (2012:70) as a systematic, organized presentation of what has been published with the aim of shedding light on what is currently known regarding the topic of interest. In qualitative research, specifically phenomenological studies, literature should only be reviewed after data collection and analysis to prevent the researcher from being influenced by the literature (Brink et al 2012:72). This study follows phenomenological approach of qualitative design and reviewed literature will be compared with the study findings to determine knowledge gap.

#### **3.4.2 Phase 2: DEVELOPMENT OF RELEVANT RECOMMENDATIONS ON HOW TO PROMOTE THE UPTAKE OF VMMC AT A HOSPITAL IN MORIJA, LESOTHO.**

This is the phase where the researcher used collected data to formulate appropriate recommendations on how to promote the uptake of VMMC at a hospital in Morija, Lesotho. Deductive reasoning was used to formulate recommendations to promote uptake of VMMC and literature was reviewed to enhance the trustworthiness of the recommendations. These detailed recommendations are covered in chapter five.

### **3.5 MEASURES TO ENSURE TRUSTWORTHINESS**

To ensure scientific rigor, the researcher used trustworthiness criteria recommended by Lincoln and Guba (1985) as cited in Streubert and Carpenter (2011:316). The following criteria for trustworthiness were applied in the study: Credibility, dependability, confirmability and transferability.

### **3.5.1 Credibility**

This is defined as “confidence in the truth of the data and interpretations of them” and this implies congruence of the findings to the reality (Polit & Beck 2012:584). To ensure prolonged engagement, the researcher spent considerable amount of time with the participants during the interviews in order to build rapport to enable them voice their perceptions freely. Field notes on researcher’s perceptions were jotted down and kept. In addition, triangulation was made possible by conducting individual unstructured interviews and having field notes as methods of data collection. Moreover, qualitative research design, explorative, descriptive and contextual designs were used so as strength of one method can overcome weakness of the other. Peer review was done as an independent expert coded the data. Literature control was also done to link findings with the previous researches (Mavundla 2000:1573).

### **3.5.2 Dependability**

Polit and Beck (2012:584) defines dependability as reliability of data after some time, which means that the similar findings must be obtained if the study is replicated after some time in similar context. In order to ensure the same results are yielded after some time in the same context, the researcher ensured that all the processes within the study and study methods were reported in detail (dense description). This implies that the research design and its implementation were clearly explained. Mavundla (2000:1573) explains that there is a need for an independent expert to code data and in this study a colleague who holds an appropriate Degree in Advanced Midwifery was tasked to do that.

### **3.5.3 Confirmability**

Confirmability is defined as objectivity where the researcher ensures that the findings are the results and experiences of the respondents not the preferences of the researcher (Polit & Beck 2012:584). The researcher will enhance confirmability of the study by availing tape recorded information of raw data, field notes and research report for an external audit.

### **3.5.4 Transferability**

This is defined as the extent to which the findings of the study can be applicable in other settings or groups (Polit & Beck 2012:585). The researcher provided a thick description of the phenomena under investigation. This entails a detailed description on number of participants in the field work, data collection methods employed, length of data collection sessions and period over which data was collected are described (Polit & Beck 2012:588).

### **3.6 CONCLUSION**

In this chapter, research design, methodology, ethical considerations and measures to enhance trustworthiness of the proposed study were discussed in depth. The next chapter presents research findings and data analysis.



## **CHAPTER 4**

### **RESEARCH FINDINGS AND LITERATURE CONTROL**

#### **4.1 INTRODUCTION**

This chapter presents findings identified from the data collected from male clinic clients in Lesotho. These findings are discussed with reference to reviewed literature in order to contextualize the findings. The main aim of the study was to gain understanding of the perceptions of men regarding VMMC at a male clinic in a hospital in Morija Lesotho. Data was collected using in-depth individual unstructured interviews and field notes among ten (10) men who volunteered to participate in the study. Tesch's method of descriptive data analysis was followed. In this study, the researcher identified four (4) themes, namely: (1) perceived health beliefs of men about circumcision, (2) perceived community held beliefs about circumcision, (3) men's knowledge regarding circumcision, and (4) perceived misconceptions about circumcision. These findings are presented in the form of description in order to emphasize facts. The researcher further included verbatim quotes from the participants.

In this chapter, participant's characteristics are described and field experience is discussed. In the second place, main themes that emerged are discussed; and lastly the concluding remarks made.

#### **4.2 PARTICIPANT'S CHARACTERISTICS**

A total of ten (10) participants were interviewed inclusive of three (3) who were selected for piloting. The participants in order to be included in the study had to meet the following criteria: They had to be uncircumcised men attending male clinic seeking other health services rather than VMMC, be above 18 years of age, be willing to participate in the study and be able to provide informed consent.

Age of the participants ranged from 29 to 83 years. Most of the participants were married Christians and were from the urban areas. One participant did not attend school at all while most dropped while in primary school. Most of the participants were unemployed,

while few were employed, self-employed or retired. All the participants preferred to be interviewed in their mother tongue (Sesotho), and data collection continued until no new information was provided by the participants.

Table 4.1 depicts characteristics of participants according to age, marital status, residence, level of education and employment status.

**Table 4.1 Characteristics of the participants**

<b>Participant code</b>	<b>Age</b>	<b>Marital status</b>	<b>Religion</b>	<b>Residence</b>	<b>Level of education</b>	<b>Employment Status</b>
1	57	Married	Christian	Urban	Primary	Self employed
2	49	Married	Christian	Urban	None	Employed
3	73	Widow	Christian	Urban	Primary	Unemployed
4	33	Single	Christian	Urban	Secondary	Unemployed
5	83	Married	Christian	Urban	Primary	Retired
6	37	Single	Christian	Rural	High School	Self employed
7	36	Married	Christian	Urban	Secondary	Unemployed
8	43	Married	Traditional Sesotho & Christian	Urban	Primary	Self employed
9	29	Single	Christian	Urban	Secondary	Employed
10	53	Married	Christian	Urban	Primary	Unemployed

### **4.3 FIELD EXPERIENCE**

During data collection before entering the field, the researcher wrote a request letter to the Medical Superintendent of the hospital explaining the purpose of the study and how confidentiality of potential participants was to be maintained. After permission was granted, the researcher visited the male clinic to make arrangements for data collection. The researcher then presented the letter of permission to conduct the study to the clinic manager and explained the purpose of the study. After the clinic manager was informed by the researcher about the method of data collection that was to be employed in this study, which was face-to-face individual interviews, the manager offered a spare room to

the researcher to use for the entire period of data collection. The researcher was made aware that he could only conduct the interviews during the week from Monday to Friday as those were the working days for the clinic.

On daily basis from Monday to Friday, a morning prayer is held at the waiting room of the clinic before day routine starts and then health education on various topics is given by the clinic staff. After the health education, announcements are made and that was the moment that the researcher was given chance to talk about this study with the aim of recruiting the study participants. A researcher introduced himself and explained the purpose of a research as part of study to gain understanding of the perceptions of men regarding VMMC at a male clinic in a hospital in Morija Lesotho.

The criteria for inclusion in this study (uncircumcised men above 18 years attending male clinic and seeking other health services rather than circumcision, who are willing to participate and able to provide informed consent) and issues relating to informed consent were also shared with prospective participants. Prospective participants were made aware that data was to be gathered by a means of a face-to-face individual unstructured interview lasting approximately thirty to sixty (30-60) minutes depending on participant's responses. Prospective participants were then informed that they might be interviewed in a private space either immediately after being attended to by a health care provider or while awaiting services. Interested prospective participants could meet the researcher and agree on convenient time to be interviewed.

Interviews were conducted in a private space at the clinic after an appointment had been set. Introductions were done, the purpose of the study explained, as well as issues relating to voluntarism, anonymity and confidentiality. Participants were briefed on the process to be followed, which involved digital recording of interviews. After participants agreed to take part in the study, a consent form was provided that laid out the nature of their commitment. The participants were provided with pseudonyms and demographic questions were asked at the beginning of each interview in order to put them at ease. They were then asked: *"What is your understanding regarding voluntary circumcision?"* Then the participants were offered an opportunity to reply to this central question.

In order to ensure that the central question was adequately addressed during the interviews, the researcher used facilitative communications skills, which included

facilitative statements and facilitative questions as outlined by Mavundla et al (2001:18). The following facilitative statements were used depending on participant's response: reflecting the content, questioning, clarifying, paraphrasing and probing. In addition, the following hand written notes were recorded by the researcher as part of observations of non-verbal cues: Methodological, personal, theoretical, observational notes and these were discussed in chapter 3.

The interviews were audio recorded and later transcribed verbatim to ensure that the data is participant's actual responses not the researcher's views. Pilot interviews were conducted with three (3) participants in order to test feasibility of the study and to assess appropriateness and quality of data collection instrument which is the interview. Transcribing and coding of data was time consuming as participants were interviewed in their vernacular.

#### 4.4 THEMES ON PERCEPTIONS OF MEN ON VOLUNTARY CIRCUMSICION

Four main themes that emerged during data collection and analysis are: Perceived health beliefs of men about circumcision, perceived community held beliefs about circumcision, perceived misconceptions about circumcision and men's knowledge regarding circumcision. Each theme has been divided into categories, of which some categories are subdivided into subcategories.

**Table 4.2 Themes, categories and subcategories**

Themes	Categories	Subcategories
Perceived health beliefs of men about circumcision	Protection from diseases	<ul style="list-style-type: none"> <li>• Reduces risk of HIV/AIDS infection</li> <li>• Reduces risk of sexually transmitted infections (STI)</li> <li>• Reduced chances of cervical cancer</li> <li>• Need to use condoms even if circumcised and avoid multiple sexual partners</li> </ul>
	Sexual beliefs about circumcision	<ul style="list-style-type: none"> <li>• Increased sexual pleasure as exposed glans penis is more sensitive during sex</li> <li>• Promotes full penile erection and circumcised penis is more cosmetically attractive</li> </ul>
	Personal hygiene	<ul style="list-style-type: none"> <li>• Circumcised penis does not collect dirt and circumcision improves penile hygiene</li> </ul>

Perceived community held beliefs about circumcision	<ul style="list-style-type: none"> <li>• Traditional obligation and passage to manhood</li> <li>• Religious obligation</li> <li>• Stigma against not being circumcised</li> <li>• Desire to be circumcised by a specific male nurse</li> </ul>	
Men's knowledge regarding circumcision	Personal knowledge	<ul style="list-style-type: none"> <li>• Limited knowledge on circumcision</li> </ul>
Perceived misconceptions about circumcision	Right time for circumcision	<ul style="list-style-type: none"> <li>• To be done in winter to promote faster wound healing</li> </ul>
	Contraindications of circumcision	<ul style="list-style-type: none"> <li>• Crooked penis</li> <li>• HIV positive men</li> </ul>
	Age at circumcision	<ul style="list-style-type: none"> <li>• Circumcision not done to elderly men</li> </ul>
	Myths on circumcision	<ul style="list-style-type: none"> <li>• Protective effects of the foreskin</li> </ul>
	Attitudes towards circumcision	<ul style="list-style-type: none"> <li>• Pain causing procedure</li> <li>• Death can occur during or after the procedure</li> </ul>

#### 4.4.1 Health beliefs about circumcision

This theme emerged as participants explained that there are some health beliefs about circumcision even though they are not circumcised. These beliefs are in terms of health benefits, which can either benefit men, women or the whole community. Maibvise and Mavundla (2018:9) developed a model to promote uptake of male circumcision and in their model, they explain that health related intervention is likely to be adopted if perceived benefits and/or the efficacy of the intervention outweighs perceived risks or barriers of adopting it. In addition, Maibvise and Mavundla (2018:16) explain that individual's perceptions and knowledge play a major role in behavioural change. This implies that if an action is perceived positively and an individual is knowledgeable about it, he/she is likely to change behaviour. Within this theme, most participants have positive perceptions towards VMMC and they are also knowledgeable about the benefits of circumcision, so

these positive perceptions can be used as motivators to undergo VMMC. This study revealed the following perceptions on health beliefs about circumcision: Protection from diseases, sexual beliefs about circumcision and personal hygiene.

#### **4.4.1.1 Protection from diseases**

Most of the participants explained that they perceive VMMC as a means of protecting men and women from diseases. These diseases include HIV/AIDS, STIs and cervical cancer. Almost all the participants explained that circumcision provides a certain degree of protection from diseases and men must also make use of other protective methods against diseases. Some emphasised the need to use condoms and be faithful to their partners in order to be protected from HIV/AIDS and STIs. This is consistent with the findings of Maibvise (2012:79) which explain that men had an understanding that circumcision protects one from diseases such as HIV and STIs. This is what some participants said about protection from diseases:

*It is important because when you are circumcised, you are protected from many diseases. These days we only concentrate on HIV and neglect other diseases, and these neglected diseases are the one which makes us sick because we are just concentrating on one disease.*

*It is important because in these days we live in an era of infections. So the importance of circumcision is that it reduces infection.*

*My view on circumcision is that I have always perceived it as a good thing since I heard about it...*

- **HIV/AIDS Prevention**

In addition to protection from diseases, some men in this study perceive VMMC as a strategy to protect one from HIV infection. Most of the study participants had an understanding that circumcision reduces chances of being infected with HIV and that circumcision does not offer 100% protection from HIV. This is what participants said in relation to their protection from acquiring HIV prevention:

*It is said that voluntary circumcision can reduce chances of HIV infection and that is how I understand it.*

*Voluntary circumcision is very important to us men and to all those who we are involved in sexual relations with. We have been taught that removal of the foreskin reduces chances of HIV infection.... Yes, it reduces chances of being infected with HIV by 60%.*

On the other hand, Maibvise and Mavundla (2014:283) explain that in the study they conducted, some men still believe that a circumcised man and uncircumcised one have the same risk of being infected with HIV and circumcision does not reduce chances of being infected with HIV.

When one participant was asked on how he knew that circumcision reduces chances of HIV infection, this is what he said:

*This information I got it from listening to radio programs which talk about reduction of HIV infection and I do believe that it is like that.*

When answering the question on how circumcision protects one from HIV, there were three different responses from the participants. One participant believes that the foreskin collects dirt which predisposes one to HIV infection while the other one believes that when one is not circumcised, the foreskin provides a good medium for HIV infection. Some participants did not know the exact mechanism of how circumcision protects one from HIV. This is what they had to say:

*So it is very important to be circumcised because we all have that area where HIV can attach. I have heard that when you are not circumcised; HIV gets a place where it can hide but when you are circumcised, there is no where it can hide.*

*Through my observation, HIV is included there because when I engage in sexual relations with an infected female partner, she is likely to give me the infection too. This is made possible by the presence of the soft foreskin which collects dirt.*

*Lately we are talking about HIV infection and it is said that removal of the foreskin helps to reduce HIV infection but I do not know on how this circumcision helps in reduction.*

The perception of circumcision in reducing chances of HIV infection is also supported by various literatures. Nevin et al (2015:10) explain that there is a clear relationship between male circumcision and HIV. Gasasira et al (2012: Online) explain that in Rwanda, 50% of the study participants were willing to get circumcised because they understood that circumcision prevents HIV. In addition, this is also supported by Peltzer (2013:5417) who conducted a study in South Africa where 40% of the respondents indicated that circumcision prevents HIV and this goes hand in hand with clinical trials conducted in South Africa, Uganda and Kenya which explain that circumcision reduces heterosexual transmission of HIV by 60% (Nevin et al 2015:1).

- **Sexually transmitted infections (STIs)**

Circumcision is also perceived by some participants as a strategy to prevent the spread of STIs from an infected female partner to the uninfected male. This perception shows that some study participants are knowledgeable that circumcision reduces chances of contracting STIs. This is what one participant said when asked which diseases he is referring to that is prevented through circumcision:

*Other sexually transmitted diseases*

Some participants even voiced out some types of sexually transmitted infections that can be prevented by circumcision as the following:

*... Vaginal discharge from women”, “....I think that is the major danger that can lead to penile discharge.*

On the other hand, Maibvise and Mavundla (2015:7) explain that some men believe that if one is circumcised, he is 100% protected from STIs. Other participants said the following in relation to circumcision as a preventive strategy of STIs:



*I see it as an important thing because of the life we have this days, there are many sexually transmitted infections..... It (foreskin) makes a man more vulnerable to sexually transmitted infections.*

Some participants even portrayed a deeper understanding of relationship between HIV and STI and this is what one said:

*...This is because when the foreskin has some lesions, those lesions increase chances of HIV infection.*

Van Dyk (2012:86) supports the above belief because STIs makes one susceptible to HIV infection. When one has an STI, T lymphocytes which have receptor sites for HIV, migrate to the STI site hence increasing chances of one being infected with HIV.

This shows that some participants are aware that circumcision has a protective effect in relation to STIs. Different studies show that male circumcision reduces chances of one being infected with STIs. Gasasira, et al (2012: Online) explain that in Rwanda, 50% of their study participants were willing to get circumcised because they understood that circumcision prevents STI's.

- **Need to be faithful and use condoms**

Some study participants were of the view that even if one is circumcised, there is still need to use condoms and be faithful to their partners. Lesotho Ministry of Health (2016:4) classifies faithfulness and use of condoms as general HIV prevention methods. Some participants are aware that even if one is circumcised, there is a need to use condoms to prevent HIV or other STIs. This is what some participants had to say in relation to condom use:

*It is encouraged that we use condoms but if one falls in love too deeply; he does not consider the sexual history of that partner or whether that partner has multiple sexual partners. So, during sexual intercourse a condom is never used and that leads to problems.*

*No, he must also use protection even if he is circumcised...condoms.*

*According to me, I would advise him to use condoms. This is because it reduces chances by 60% not 100%.*

*If a man understands the main cause of the disease and having knowledge of condom utilization he is protected. You will see most of the cases if one uses condoms.....*

Use of condoms is advised to the circumcised and uncircumcised men to prevent the spread of HIV and STIs. Naidoo et al (2012:Online) also support the above notion as they explain that results of their study indicated that over 92% of their study participants had knowledge that circumcision alone is not as effective as condom use in HIV prevention. This implies that even if a man is circumcised, he must still use a condom during sexual activity to prevent HIV and STI transmission.

One participant had a different view about condom use and circumcision. He pointed out that the foreskin protects the penis from condom lubricants which can cause ill health. He said that circumcised penises are at risk of ill health because the foreskin that covers and protects the glans penis has been removed and condom lubricant will come in contact with the unprotected glans penis. This is what he had to say:

*Again, these condoms we use have some kind of lubricant that we do not know its origin. So during sex, this lubricant comes in contact with circumcised “naked penis” which may even cause other diseases and this was my main concern.....Some people think that if they are circumcised, they cannot use condoms during sex.*

Circumcision is also opposed by Jia et al (2014:132) who explain that male circumcision is regarded as an insane procedure because removing foreskin while there is nothing wrong with the penis shows people's minds do not work well.

Having multiple sexual partners whether circumcised or not was viewed as a risky behaviour by some participants as this can predispose one to HIV and STIs. This is what some participants said:

*Emmm, my view is that as human beings we need to avoid HIV infection by various ways such as by not engaging in many sexual activities, things like that..... To be engaged in sexual activities with many women.*

Some studies explain that circumcision lead to multiple concurrent sexual partners and refute the above belief. Some men and women have a belief that male circumcision fuels the spread of HIV. In the presence of multiple sexual partners, HIV can spread with ease from one infected partner to the uninfected one. This is supported by Naidoo et al (2012: Online) as they explain that from the study they conducted, some of the study participants regarded male circumcision as undermining existing protective behaviours and strategies. This implies that circumcised men may freely engage in unprotected sexual activities thinking that they are 100% protected from HIV.

In Lesotho, the notion of VMMC fuelling the spread of HIV and promiscuity has been addressed to the communities through media and positive messages on VMMC have been passed (Public Eye 2017:19).

- **Circumcision and reduction of Cervical cancer**

There is a belief among some study participants that male circumcision reduces chances of cervical cancer on women. This implies that male circumcision does not only offer protection to men, but women are also benefiting. This is what one participant had to say in relation to cervical cancer:

*Yes, even in women the foreskin still causes dangers... Ones like cervical cancer and so on.*

This participant believes that the foreskin can still cause ill health in women, just like it does in men. Human Papilloma Virus (HPV) is the major cause of cervical cancer in women (NHS 2018: Online). Maibvise (2012:84) explains that uncircumcised penis is at the risk of developing HPV hence uncircumcised men are likely to transmit that HPV to their sexual partners. In the early years, some physicians believed that circumcision reduces the risk of other cancers and conducted the procedure based on above believes (Henerey 2004:271). Once a female partner is infected with HPV, she is at a higher risk

of developing cervical cancer. In the northern countries, circumcision was advocated as a preventive measure against masturbation, syphilis and penile cancer (WHO 2007:11).

#### **4.4.1.2 Perceived Sexual beliefs about circumcision**

Mary (2010: Online) explains that sexual development in men takes various stages. In adolescents, sexual behaviour is normative as penetrative vaginal intercourse tends to increase with age. This is the stage where they explore sexual relationships and this makes them more vulnerable to be infected with STIs. According to advocates for youth (2008: Online) after puberty, men have increased interest in sexual relationships and explore various sexual behaviours such as masturbation, genital touching and sexual intercourse. According to the study participants, circumcision tends to have an effect on sexual intercourse as it improves sexual pleasure and promotes full penile erection. In addition, a circumcised penis is viewed as more cosmetically attractive than an uncircumcised one.

- **Improved sexual pleasure**

Some participants explained that circumcision improves sexual pleasure in both men and women. Some attributed the increased sexual pleasure to the exposed glans penis which becomes more sensitive during sexual intercourse. In relation to improved sexual pleasure, this is what some participants said:

*They say that when one is circumcised and have sex with a woman, he feels more pleasure, unlike that time when he was doing sex without circumcised penis. He gets that inner part of women when he is circumcised.*

The same participant also explained that he also has a fear that as circumcision improves sexual pleasure; his wife is likely to be attached to men who are circumcised. This is what he had to say:

*There is another thing I am suspicious about, that I am thinking of it. When I go to work, I leave my wife at home and she can have extra marital relationships. So my worry is that am I unable to give pleasure to her as compared to a man who is circumcised. As people say circumcised men give women more pleasure than un-*

*circumcised ones, so I am worried that these circumcised men may tend to be loved more by my wife.*

One participant explained that he has never discussed relationship between circumcision and sexual pleasure with his sexual partner, but there is a saying that circumcised men perform well during sexual intercourse. In addition, most men explained that the issue of improved sexual pleasure is something they heard about and they cannot confirm it as they are not circumcised. This is what they had to say:

*I have never discussed that with my girlfriend but it is said that women say men who are circumcised are performing well during sexual intercourse as compared to uncircumcised men.*

*The other thing that I heard is that when one is circumcised, there is much sexual pleasure during sexual intercourse.*

Even women have noted the difference of sexual pleasure between circumcised men and uncircumcised ones. Women even go to an extent of encouraging their sexual partners to be circumcised. Maibvise, Mavundla and Nsibandze (2017:3) support the above fact as they explain that girlfriends tend to pressurise their boyfriends to be circumcised. This is what some participants said in relation to what women say about sexual pleasure:

*This is what women say: During sexual intercourse, when one is circumcised, there is more pleasure during sexual activity.*

*I heard it from women because my girlfriend says I must get circumcised. Then I asked her whether she had sex with someone who is circumcised and noted the difference between sexual pleasures. She said she has no experience and she will be shy to talk. But people say there is more pleasure when one is circumcised and most of them do unprotected sexual intercourse.*

Even though this participant is not circumcised, he explains that when his foreskin is retracted back during sexual intercourse, he feels much pleasure as compared to when the foreskin is still covering the penis. This is what he had to say:

*I am not circumcised as I said! So when I engage in sexual activity, there is a time when the foreskin is retracted back and I feel a difference in pleasure when it is retracted.*

There is a belief that there is a relationship between male circumcision, sexual pleasure and performance Gao et al (2015:1). Women aged 15-49 years in a study conducted by Maraux, Lissouba, Rain-Taljaard, Taljaard, Bouscailou, Lewis, Puren & Auvert in 2017 explain that they believe that circumcision increases pleasure during sex while 15% disagrees with that (Maraux et al 2017). This belief is also supported by a study conducted by Gao et al (2015:1) and Peltzer (2013:5417) who argue that circumcision increases men satisfaction during sexual intercourse. Increased sexual pleasure is attributed to the fact that the glans penis which is regarded as most sensitive is exposed during sexual activity.

- **Full penile erection and cosmetically attractive penis**

Some participants had some views that uncircumcised penis does not erect to its full capacity. This was attributed to the presence of the foreskin which restricts full penile erection. They believe that if a penis is circumcised, it is likely to get fully erect during sexual intercourse, which later leads to increased sexual pleasure in men and women. This is what two participants said in relation to full erection of the penis:

*One other reason that I have noted is that, when the foreskin is still in place, a men's penis does not get full erection... The penis does not get straight, it gets slanted... because when this thing [foreskin] has been removed, the penis gets relaxed and when one makes sexual intercourse, it is easier and there is nothing that causes problems. This is according to my observation.*

*That is when I realized that this [foreskin] needs to be removed so that the penis can be erect.*

Fink, Carson and Devellis (2002:2114) debate that their study participants explained that circumcision reduced their erectile function. The kind of erection they had prior circumcision is reduced and they cannot maintain erection for long. This is contrary to

what the above participants believe. Yang, Tsao, Wu, Chuang, Meng, Sun, Yo, Chang and Cha (2013:308) explain that circumcised men have erection confidence and they are able to maintain penile erection for longer period of time.

On the view of cosmetically attractive penis, one participant explained that even though he is not circumcised, he views circumcised penises as cosmetically attractive. This implies that the penis is looking good and it is aesthetically pleasing. When one thinks that his penis is cosmetically attractive, this can boost his self-image and speak freely about circumcision. This is supported by Maibvise and Mavundla (2013:144) who explain that enlarged foreskin distorted the physical appearance of the penis forcing some men to be circumcised. This is what the participant had to say:

*...circumcised penis looks more beautiful cosmetically unlike the uncircumcised one which does not look good at all.*

Fink et al (2002:2115) explain that some people decide to circumcise their children because they want to make them look better. This implies that they want their boys to look more cosmetically attractive. To add on this, they also explain that during a survey, women explained that they like pictures of circumcised penises as compared to the uncircumcised ones. Henerey (2004:27) explains that some parents circumcised their children for cosmetic reasons as they wanted their children's penis to look more beautiful and to resemble other males.

#### **4.4.1.3 Personal hygiene**

Maibvise and Mavundla (2018:16) explain that if an action is perceived positively and an individual is knowledgeable about it, he/she is likely to change behaviour. In this context, circumcision is perceived positively because it is viewed as a strategy to promote personal hygiene. Improved personal hygiene improves self-esteem leading to improved self-confidence. Orem's self-care theory is based on the assumption that people need to be self-reliant and be responsible for their own care (Nursing theories 2012: Online). Some men in this study show that being circumcised make one responsible for own care as good hygiene is promoted. Participants explained that circumcised penis does not collect dirt and circumcision improves penile hygiene.

- **Penile hygiene**

Some participants had an understanding that the foreskin harbours dirt within it. This dirt can build up at any time even after bathing. The whitish substance found under the foreskin “smegma” is composed of shed epithelial cells and sebum which is produced by sebaceous glands (Murtaza 2015: Online). Under normal circumstance, smegma prevents friction as it lubricates the foreskin and the penis during sexual intercourse. If that lubricant is absent, that can lead to friction causing abrasions to the foreskin. This is what some participants had to say in relation to the penile hygiene:

*I have seen that when there is a foreskin, I have noticed the foreskin sometimes collects some dirt... This happens, emmm in other words, the dirt does not collect only after sexual intercourse. You will find that this [foreskin] acts as a cover and there is white dirt that looks like “pap” of which Basotho men call it “mokhona”. So that is what I hate.*

*Uncircumcised penis has whitish substances which they call them “pap”. So you will understand that uncircumcised penises are not clean and that is according to my understanding... It is very clear that circumcision promotes penile hygiene.*

*Emmm, I believe that a foreskin can harbour dirt or microbes from women during sex but if it is removed, there are few chances of taking the dirt or microbes from women.*

*So when the foreskin is removed, it is clear that dirt will not take advantage of being trapped on the penis....Yes, because when the foreskin is still there, after sex the foreskin goes back to its original position and covers the dirt inside. Sometimes as Mosotho man you meet someone at Mohale’s Hoek and have sex and you are on the journey you will bath tomorrow. That time prior bathing, the foreskin has covered dirt inside and something is happening at that time.*

*There is dirt and when you bath, you will have to bath like a woman. All days, I have to retract the foreskin so as I bath well.*



The issue of penile hygiene is not only a concern to men. Some women also have some views about circumcision and hygiene as this is evidenced by the following quote:

*Women talk especially about the hygienic status of a circumcised man and the uncircumcised one. They say circumcised men have good hygiene as compared to the uncircumcised ones.*

Evidence suggests that uncircumcised penis can harbour various microorganisms and dirt. This is made possible by the presence of foreskin which is a good medium for microbial growth. Gasasira et al (2012: Online) conducted a study in Rwanda which explored knowledge and perceptions of Rwandan men on male circumcision and to determine factors associated with willingness to be circumcised. Half of the respondents perceived circumcision as a good strategy of improving penile hygiene. This is because foreskin which harbours microbes and dirt has been removed.

Peltzer (2013:5417) and Macintyre et al (2014:4) support the above belief as they explain that it is believed that men carry a lot of dirt after sexual activity especially under their foreskin and circumcision can improve penile hygiene. This perception of improved penile hygiene must be emphasised during community outreaches as literature supports male circumcision as a strategy of improving penile hygiene.

#### **4.4.2 Community held beliefs about circumcision**

Group of people with similar characteristics who reside in the same geographical area makes a community. These people share the same values, norms and morals. In this study, participants are from different communities which have different values, norms and morals. Some come from urban communities while others are from rural communities. It is evident that men's perceptions are influenced by the way they are socialised. In this respect, men's perceptions were based on tradition and religion. This theme emerged as participants explained that circumcision is viewed differently by various communities or groups. Maibvise and Mavundla (2018:16) are of the view that health care providers need to work hand in hand with men's social support system (relatives, spouses, community and spiritual leaders) because this system play a major role in influencing one to be circumcised. In this theme, men's perceptions were based on tradition and religion. In addition, stigma associated with circumcision were voiced out.

#### 4.4.2.1 Traditional obligation and passage to manhood

In some cultures, circumcision is viewed as a traditional obligation and a male is obliged to be circumcised in order to be regarded as a man. The inference that can be drawn here is that circumcision is regarded as a passage to manhood. Mavundla et al (2009:401) explain that for a Xhosa male to be regarded as a man, he needs to pass through circumcision ritual. A male needs to meet his obligation of being circumcised and if not circumcised, he will be regarded as a “boy” until he is circumcised. Mavundla et al (2010:6) explain that in Xhosa culture, uncircumcised men are labelled as “boys” and such men do not enjoy the same respect that is offered to circumcised men and they are rejected by the community, peers and their families. One participant who is former miner had to say the following about traditional obligation and passage to manhood:

*The reason is that according to Sesotho culture, it is correct for a man to be traditionally circumcised. According to my view, I think it would be easier for every man to be circumcised and this will imply that he is initiated... Yes it is. I have worked with the Xhosas of Transkei in Republic of South Africa in the mines. So, Xhosas when you are in the “change house” and bath, they look at your genitals. If they see that the head of the penis is exposed and there is no foreskin, they will say “Indoda lena”. But when the penis is still covered with the foreskin, they will call that person a boy. “Inkwenkwe” In Sesotho this means “moshanyana” this one is a boy...*

In other cases, traditional circumcision which happens in mountains at the initiation schools was also viewed differently from VMMC. Males who are traditionally circumcised are regarded “men” while those who went for medical circumcision are still regarded as boys. There is discrimination between men who are traditionally circumcised and medically circumcised as evidenced by the following quote:

*There was some discrimination as ones who were not traditionally circumcised were regarded as boys and those traditionally circumcised were regarded as men.*

Some nations are traditionally circumcising while others are not. Macintyre et al (2014:3) explain that men over twenty five (25) years of age regarded circumcision as a tradition

of some tribes and if they get circumcised, this implies that they are leaving their tradition for a different one. This clearly shows that male circumcision in other parts of Kenya is perceived as a tradition of some tribes. Corduk et al (2013:171) supports the above belief as they explain that in Turkey, 30% of their study participants explained that they regard circumcision as a mission or obligation. This implies it is their duty to be circumcised as boys because circumcision is part of their tradition.

Howard-Payne & Bowman explain that some men perceived that men who are medically circumcised are more masculine than uncircumcised one. This is because it is believed that a real man must take right decision and be circumcised in order to protect loved ones from HIV infection.

Henerey (2004:266) explains that the first record of removal of penile foreskin can be traced in the early years of King Ankh Manh, approximately 3000 Before Common Era (BCE). Ankh Manh was the king of Egypt in 1333 BCE and it is during his ruling that foreskins were removed for social reasons. Males wanted to be ranked on a higher social class as a result; they had to remove their penile foreskins.

Wilcken, Keil and Dick (2010) are of the view that in Africa, male circumcision was initially carried out for cultural reasons. This procedure has been performed in a non-clinical setting by traditional doctors who have no formal training on medicine and surgery. Wilcken and colleagues also argue that this procedure is carried out as a rite to transition into manhood and it is mainly performed on adolescents and young men. Susman (2000) as cited by Mavundla et al (2009:395) explain that circumcision in Africa has been done from long time ago although there is no documented evidence of such.

#### **4.4.2.2 Circumcision as a religious obligation**

An elderly man aged 73 years explained that according to his Christianity religion, it is duty of every man to be circumcised. He regards circumcision as a pact between man and God. Maibvise and Mavundla (2014:107) explain that some Christian men went for circumcision because they wanted to look like Jesus Christ as he was circumcised. This is what the participant had to say in relation to religious obligation:

*About the Bible, God commanded all Israelis men and boys to be circumcised. So when one is not circumcised, he is termed “leqai”, meaning just a boy. Uncircumcised Israel men died along the way and God made a promise that all Israel male must be circumcised. After they were all circumcised, there were no longer deaths of men encountered. This implies that according to me, all men in Lesotho must be circumcised.*

In the Christian Bible David brought 200 foreskins of Philistines to his king Saul in exchange for rights to marry Saul's daughter (Henerey 2004:267). Jews adopted and ritualized circumcision as it is explained in Genesis 17:10-14 that circumcision was a sign of pledge between God and his people and any uncircumcised man will be cut off from the community because he has broken the promise with God (Old Testament 2011:13). On the other hand, Maibvise and Mavundla (2014:283) explain that some men are against circumcision because it is against their Christianity religion. They explain that it is God created a man with a foreskin and removing it will be damaging the temple of God.

#### **4.4.2.3 Circumcision and stigma**

Men who are not circumcised are stigmatised and they are even scared to expose their circumcision status to their peers. One elderly man explained that he does not talk about circumcision issues with other men. The reason for not discussing circumcision with other men is that he fears to be stigmatised that he is not circumcised as most men are circumcised. Mavundla et al (2010:6) explain that in Xhosa culture, an uncircumcised man is labelled inferior to his age mates who have undergone the procedure. This is what the participant had to say in relation to fear of exposing his circumcision status:

*The reason that I am not talking to people about it is that I know myself I am not circumcised, so I do not know what others will say if they find out that I am not circumcised.*

Medical circumcision and traditional circumcision seem to be interpreted differently by some men. Some men are of the view that a medically circumcised man who never went through the traditional initiation ceremony is still labelled as a boy. They do not consider whether one has a foreskin or not but what they consider is whether one has passed through the initiation ceremony or not. This is what one participant had to say in relation to medical and traditional circumcision:

*Xhosas are different from Basotho because with Basotho when you are circumcised here at Scott, they are going to discriminate you because you never went to the mountains for traditional circumcision and they regard you as a “boy”. On the other hand, Xhosas when they see you during bathing time that you have removed the foreskin, they regard you as a man... Yes, “Indoda lena” in Xhosa. They don’t even care whether they have seen you up in the mountains for traditional circumcision, only if they see that one does not have a foreskin, they say “Indoda lena man”, and this is a real man...*

In Lesotho, male circumcision started even before 1820 where it was regarded as a transition to manhood. Young boys were taken to initiation schools to be taught about Basotho’s culture and expected behaviours and the traditional doctors were the ones doing circumcision (Walls 2014: Online). Uncircumcised men are regarded and labelled as “boys” and this causes a shame to the males who are regarded as “boys”.

#### **4.4.2.4 Desire to be circumcised by a specific health care provider**

Clients have a right to be provided services by a health care provider of their choice. This seems to be true in this context as one of the participant’s explains that he wants to be circumcised by a specific male nurse. The reason for his choice is that he has developed a good relationship with the nurse and he trusts him. This is what the participant said:

*The main reason I like that male nurse is that I have trust in him... I have consulted him several times when I was ill and he understands me very well. When we need to discuss, he is patient and gives me all the attention... Yes there is a good relationship... No, I do not find any alternative except that male nurse because I feel free when I am with him as we are able to discuss. I once asked him to circumcise me, but he said there are other people in the clinic that can circumcise me. But I said “I want to be assisted by you not any other person”...*

#### **4.4.3 Perceived misconceptions about circumcision**

Maibvise and Mavundla (2018:9) explain that low uptake of male circumcision is attributed to negative perceptions about the procedure, which are rooted in individual psycho-socio-

cultural backgrounds or experiences, as well as misinformation and misconceptions about male circumcision. In addition, they state that individual knowledge and perceptions are dynamic. Thus, the specific misconceptions and negative perceptions that account for low male circumcision uptake vary with time and from place to place. In this study men have different misconceptions about VMMC and the following misconceptions were evident: Right time for circumcision, contraindications for circumcision, age for circumcision, myths and attitudes towards circumcision.

#### **4.4.3.1 Right time for circumcision**

Time of the year to be circumcised depends on individual's preference. Some men prefer to be circumcised in summer while others prefer to be circumcised in winter. Some men said that if they are circumcised, they prefer to be circumcised in winter as wounds heal faster.

- **Procedure to be done in winter to promote faster wound healing**

Some participants in this study explain that they perceive the right time for circumcision as winter as compared to other seasons of the year. Winter is perceived as the right time because they believe that it is cooler and the wound dries faster, hence reduced chances of delayed wound healing and sepsis. This is what the participants had to say in relation to right time for circumcision:

*So I have realized that if I can have a wound in summer, there is a chance of that wound to be septic but if I can have a wound in winter it heals faster... Increased temperature is the main cause. You will also see that food in summer does not stay fresh for long.*

*Any the time of the year is fine. There are those people who may have delayed wound healing in summer and I have heard that winter is the best time for the procedure... It is because in winter it is a bit cooler which reduces chances of delayed wound healing.*

*...We worked very hard in the mines and it is extremely hot in there. I remember a Xhosa guy who got circumcised while we were still working at the mines; He ended*

*up limping because his circumcision wound delayed to heal due to the extreme heat.*

Men have different beliefs on when to do circumcision as others prefer to do it during certain seasons of the year. Public eye (2017:17) explains that Basotho men prefers to be circumcised during winter because they belief that winter allows faster healing than summer. Messages need to be passed that every season is the right time to undergo circumcision as healing occurs naturally.

#### **4.4.3.2 Contraindications for circumcision**

There are those situations that are perceived by some participants that can prevent one from being circumcised. According to the participants, they received that information from the health centre and from some of the community members. If the penis is not straight and it is crooked and also one is HIV positive, circumcision cannot be performed on such individuals.

- **Crooked penis**

Slanted penis cannot be performed circumcision as perceived by some of the study participants. The rationale for not circumcising the slanted penis is unknown to that participant. This is one of the misconceptions that need to be corrected so as more men can be circumcised. This is what the participant had to say in relation to the crooked penis:

*The younger one is not yet circumcised because when we took him to circumcision, it was said that his penis is not straight... They did not provide the explanation why a crooked penis is not circumcised since the boy was brought by my wife to the hospital.*

Imm (2015: Online) explains that even in a condition known as “Peyronie’s disease”, the penis can still be circumcised. Peyronie’s disease occurs when fibrous tissue develops on the shaft of the penis leading to bending of the penis, painful erection and difficulty in heaving sexual intercourse (Imm 2015: Online). Circumcision can be performed on a patient with this disease so as to prevent foreskin to become tight on the penis. Maibvise

and Mavundla (2018:10) explain that these misconceptions and negative perceptions about VMMC account for low circumcision services and they need to be addressed.

- **HIV positive men**

Being HIV positive was perceived as a contraindication to circumcision by one middle aged man. He explained that he heard that HIV positive men cannot be circumcised and this was from a local radio station. This is because he was already HIV positive and circumcision reduces chances of one being infected with HIV. He still wants to be circumcised, but the information he has prevents him from being circumcised. This is what he said:

*So because I have a disease, I cannot be able to remove the foreskin... I heard somewhere out there...On the radio... I didn't know that I am HIV positive. The time I wanted to remove it I tested for HIV and the results were positive and I cannot be circumcised and I knew that... I had to go on with life. I thought it is important to be circumcised but when I found that I am HIV positive I felt now there is no need to be circumcised... I did not do a follow up on that one but I understand that HIV positive person's wounds do not heal with ease. His wounds delay*

HIV positive clients still need to benefit from circumcision. Circumcision does not only reduce chances of being infected with HIV but has many advantages. HIV positive clients still need to be protected from STIs and circumcision reduces chances of STIs. Nevin et al (2015:10) explain that there is a clear relationship between male circumcision and STIs. Gasasira, Saker, Tsague, Nsanzimana, Gwiza, Mbabazi, Karema, Asimwe & Mugweneza (2012: Online) explain that in Rwanda, 50% of the study participants were willing to get circumcised because they understood that circumcision prevents STIs. In addition, this is also supported by Peltzer (2013:5417) who conducted a study in South Africa where 40% of the respondents indicated that circumcision prevents STI's and this goes hand in hand with clinical trials conducted in South Africa, Uganda and Kenya (Nevin et al 2015:1).

Apart from benefiting from protection against diseases, circumcision promotes good penile hygiene. It is evident that uncircumcised penis can harbour various



microorganisms and dirt. This is made possible by the presence of foreskin which is a good medium for microbial growth (Peltzer 2013:5417) & (Macintyre et al 2014:4).

#### **4.4.3.3 Age at circumcision**

Circumcision can be done at various stages of life beginning after birth. Some men believe that they are too old to be circumcised as circumcision is for younger men.

- **Circumcision not done to elderly men with family**

Some participants do not understand why they should be circumcised because they are old and they have families. They perceive circumcision as a procedure for young men not the elderly. Those participants are aged between 49 to 70 years and they regard themselves as too old to be circumcised. This is what they said:

*I think we have discussed them all even though I do not understand why at my age I should get circumcised because I am an aged father who has children and a wife.*

*Yes, it is my aim to be circumcised but my worry is about my age. I am worried they might say I am too old for that...I am Seventy three years old.*

Men can be medically circumcised at various stages of life: This can be during neonatal period, childhood, adolescence and adulthood. Circumcision is believed to be a procedure for young and sexually promiscuous men according to Gasasira et al (2012: Online) & Macintyre et al (2014:5). This is because older men believe that to them, circumcision can lead to bleeding and delayed wound healing due to their age. They believe that circumcision should be done to young energetic men because they are still active in sexual activities. This belief needs to be explored and corrected as this acts as a barrier to utilisation of VMMC services because older men do not want to be circumcised.

#### **4.4.3.4 Myths on circumcision**

Myths are beliefs and explanations that many people believe but they are not true. Myths can be in terms of stories or tales. These myths that men have in relation to VMMC lead

to poor uptake of VMMC services. These stories do not have a scientific or literature backup. Some participants explained if one is circumcised, women's pubic hair can cause cuts to the penis because the foreskin that protects the penis has been removed. In addition, the foreskin is regarded as a protective barrier for the penis.

- **Protective effects of the foreskin**

Some participants believe that the foreskin protects the glans penis from cuts, infections and lubricants from the condoms. Some believe that if the lubricant from the condom comes in contact with the glans penis and urethral meatus of a circumcised man, that lubricant is likely to cause ill health to that person. In uncircumcised man, it is believed that the foreskin protects the glans penis and the urethral meatus from coming in contact with the lubricants from the condoms. This is what one participant had to say:

*...it was that if a new disease emerges and I do sex with a woman and the penis is naked without the foreskin, what will happen to me? Again, these condoms we use have some kind of lubricant that we do not know its origin. So during sex, this lubricant comes in contact with circumcised "naked penis" which may even cause other diseases and this was my main concern.*

In addition, some men have a belief that during sexual intercourse, pubic hair of a woman can cause cuts on the penis especially the on the glans. If a man is uncircumcised, they believe that foreskin protects the glans penis from cuts which will be caused by women's pubic hair. This is what one man had to say:

*During sex, the pubic hair of women can cause some cuts on the penis, so circumcised penis can ulcerate due to lack of protection from the foreskin... I told them that the penis is left unprotected hence vulnerable. They said that my foreskin is the one that is going to cause me diseases. At the end they say I might be correct, because pubic hair of women can cause cuts to the penis during unprotected sexual intercourse. So myself I am protected by the foreskin.*

Foreskin is also viewed as a protective mechanism against diseases and when it is removed, that predispose a man to new unknown diseases. The following is the direct quote of the participant:

*Earlier it was not known that there will be HIV infection, so when someone has removed his foreskin and other diseases emerge, there will no longer be a foreskin to protect the penis. That was the main concern.*

It is not only in Lesotho where foreskin is regarded as an important part of sex. Colombian men who have sex with other men have a various perceptions regarding the foreskin as described by Gonzales et al (2012:999). Men regarded a foreskin as an important part of sex and they prefer uncircumcised penises. This is because they prefer grabbing the foreskin, bringing it down and up (Gonzales et al 2012:999). Circumcision is also opposed by Jia et al (2014:132) who explain that male circumcision is regarded as an insane procedure because removing foreskin while there is nothing wrong with the penis shows people's minds do not work well.

The above perceptions show that there is still knowledge gap regarding circumcision and such gap need to be addressed. Maibvise and Mavundla (2018:9) explain that there is need to harmonise the understanding of the meaning of the uptake of male circumcision in the context of HIV prevention as this will help to eliminate individual biases that may negatively influence men's perceptions and decision to undergo circumcision.

#### **4.4.3.5 Attitudes towards circumcision**

Attitudes are tendencies to respond to people and events positively or negatively. These tendencies can be influenced by religion, culture and the socialization processes. Men's attitudes towards circumcision influence the uptake of VMMC services and such attitudes need to be shaped. Some men perceived circumcision as a pain causing procedure while others explained that they are not circumcised because they fear death during the procedure or after the procedure.

- **Pain causing procedure**

Some participants expressed their fear of pain and they explained that they are not circumcised due to fear of pain. Maibvise and Mavundla (2014:283) explain that fear of pain caused by surgical removal of the foreskin acts as a barrier for some men. Some

men showed understanding that before circumcision; one is given an injection to prevent pain but that injection may not last for long time. This is what some participants said:

*I am being consumed by "fear". How can I be helped to reduce my fear so that I can end up being circumcised? This is because during my years when I hear circumcision news especially when I have visited this clinic going for general consultation, nurses here advice people who are not circumcised to be circumcised until one is sixty nine years old. Now that I have not reached those years, what can I do to reduce my fear so that I get be circumcised?*

*I am very scared of pain... Yes it is. I am continuously asking myself whether I am going to feel pain or not and I think this is what made me not to be circumcised... I have seen men from circumcision but I have not asked them about pain since I fear pain.*

*Yes, I am scared of pain but it is similar to this operation... Yes it is there. I can be injected with pain block but when I go home I may have altered mobility due to decreased efficacy of the pain injection...*

Pain during the procedure is not only the main concern for men in this study. Some men explained that the technique employed by nurses when they dress circumcision wound is the one that made them to be reluctant to be circumcised. It is explained that nurses when removing soiled dressing from the wound they are rough and they just pull the dressing causing more pain and bleeding to the wound. In addition, some solutions which nurses use to dress the wound are also main reasons why they are not circumcised. It is reported that nurses use methylated spirit to clean the wound and this causes unbearable pain. This is what the participant had to say:

*They say that during the time of dressing the wound, they remove the dressing roughly causing pain and bleeding leading to delayed wound healing. I want to be circumcised but it is a bit late because I have to get back to work. Next time when I come home I will get circumcised. Is that not painful? Last time when I came for consultation, I saw some small kids crying after they were circumcised. I wondered if this circumcision really causes that much pain because I cannot deal with pain... Is because the pain injection has worn off? Then I was scared and took conclusion*

*that this procedure is painful. I actually came for circumcision that day, but then I decided to go home because of those children who were crying of pain... No, but they say when the dressings on the penis are removed, those people who remove the dressings are very rough and they also apply methylated spirit on the wound.*

Previous pain experience tends to act as a barrier that prevents some of the participants to be circumcised. One participant had an unpleasant experience where he was given an injection on the buttocks and unfortunately after that injection, the injected lower extremity became weak, swollen and painful for long time. That unpleasant experience has been in the participant's mind and he wants nothing to do with injections. This is what he had to say:

*Yes. I have this bad experience. I went to consult at Roma hospital and I was given an injection. I was injected at the bone not the buttocks and I took 2-3 months with weak leg and the injection side was also swollen. That is what made me to be scared of circumcision, incompetent people during injection*

After surgical removal of the foreskin, pain can occur because a surgical incision has been done. Some men especially under 19 years regarded circumcision as pain causing procedure (Gasasira et al 2012: Online). Corduk et al (2013:171) support the above belief as they explain that 17% of their study participants explained that circumcision is very scary and painful and they will never repeat that procedure. Public eye (2017:17) also reports that herd boys in Lesotho fear to be circumcised because of fear of pain.

Pain is seen as a barrier in utilising male circumcision services as men feared pain caused by the procedure. Men needs to be educated that before the foreskin is removed, a local anaesthetic is given to block pain and also post the procedure one is given analgesics to counter act the post-operative pain.

- **Death during and after the procedure**

Some men have attitudes towards circumcision because of fear of death. One of the participants explained that he fears that he can die while he is on the operating bed. On the other hand, one participant explained that he believes after the foreskin has been cut, that wound must not be sutured but must be left bleeding. He explained that if the wound

is sutured and blood is prevented from oozing, that is going to cause death. These are the quotations from the participants:

*No! My inner fear, I am scared that I will die while I am on the operation bed. That is the fear that I have and I am wondering how I can be helped to deal with that fear.*

*Earlier, I understood that someone after the procedure he can be affected and die... after the procedure when one is at home. I thought of that suturing thing which may cause some kind of danger... Yes that is my view, the suture material closes the blood that was supposed to be let go*

Post-operative bleeding can cause anaemia, hypovolemia, shock and death (Christensen, Krapf, Kempel & Heymann 2009:689). Surgical wounds need to be sutured to prevent post-operative bleeding. This perception needs to be corrected as this can prevent men with the same beliefs to be circumcised.

#### **4.4.4 Men's knowledge regarding circumcision**

Knowledge determination regarding VMMC to all consent is very crucial, thus why research is conducted globally to assess men and women's knowledge regarding VMMC. Knowledge on definition of VMMC and what it entails is crucial in determining whether one gets circumcised or not.

##### **4.4.4.1 Personal knowledge on VMMC**

Educational status, social background and age can determine the level of awareness of an individual on certain concepts. The educational status of participants in this study ranged from non-attendance to high school with majority of them dropping school at primary level. Some participants in this study explained that they have limited knowledge on VMMC as explained below:

- **Limited knowledge on circumcision**

Some men are still having knowledge deficit in relation to the importance of circumcision. This is evidenced by the following quote from one participant:

*Questions are questions and they are very difficult, especially that I do not know what is the importance of circumcision. Most of the times one does not have views on issues or subjects that are unknown to him unless he is educated on that subject first .Am I clear?... Yes I have limited knowledge on that issue*

One of the importance of VMMC according to Lesotho Ministry of Health (2016a:4) and Skolnik et al (2014) is that VMMC is a good strategy of reducing HIV transmission by 60%. Mugwanya et al (2010:1192) argue that some of their study participants have knowledge about protective effects of circumcision against HIV. 77% of men and 89.6% of women were knowledgeable that circumcision reduces risk of HIV-1 transmission to uninfected men and 95% of women were knowledgeable that circumcision does not offer full protection against HIV-1. In addition, more than 90% of participants had knowledge that circumcision of HIV-1 infected man does not offer protection to HIV negative female partner.

The above literature and the participant's responses show that some men are knowledgeable about VMMC while others have limited knowledge. Messages on VMMC must be tailored to meet community specific needs and all knowledge gaps must be addressed.

#### **4.5 APPLICABILITY OF THE FINDINGS TO THE MODEL**

The use of theory in qualitative research differs from its application in quantitative studies. In quantitative research, theory is used to guide research and to give structure to findings. In qualitative research, theory is used to reflect findings of the study. In the current study a model to promote uptake of male circumcision proposed by Maibvise and Mavundla (2018:16) was used as a frame of reference. This model focuses on promoting uptake of male circumcision in areas where there is high HIV and low circumcision prevalence (Maibvise and Mavundla 2018:1). Lesotho as one of the countries of the Sub-Sahara region, HIV prevalence by the end of 2014 was 25% as compared to 2009 when the

prevalence was 23% (Lesotho Ministry of Health 2016b:235). The table below shows the findings as reflected within the model.

Table 4.3: Findings as reflected within the model to promote uptake of male circumcision

Influencing individual's perceptions		Facilitating access & utilisation of safe MC services	Maintaining a supportive social support system
<p><b><i>Positive Perceptions of VMMC by men in this study</i></b></p> <ul style="list-style-type: none"> <li>• Reduces the risk of HIV infection</li> <li>• Reduces the risk of STIs</li> <li>• Reduces chances of cervical cancer</li> <li>• Need to use condoms and avoid multiple sexual partners</li> <li>• Increases sexual pleasure</li> <li>• Promotes full penile erections</li> <li>• Circumcised penis is more cosmetically attractive</li> <li>• Circumcised penis does not collect dirt</li> </ul>	<p><b><i>Negative Perceptions of VMMC by men in this study</i></b></p> <ul style="list-style-type: none"> <li>• Limited knowledge on circumcision</li> <li>• The thought that circumcision must be done in winter to promote faster wound healing</li> <li>• The thought that a man with crooked penis cannot be circumcised</li> <li>• The perception that HIV positive men are not supposed to be circumcised</li> <li>• They don't associate circumcision with the elderly men</li> <li>• Some also think that the foreskin protects the penis from cuts caused by pubic hair of women</li> </ul>	<p>Fear of complications that can arise due to circumcision</p>	<ul style="list-style-type: none"> <li>• Encouraged by the girlfriend to be circumcised</li> <li>• Circumcision is a traditional and religious obligation</li> </ul>

The research findings show that most of the participants already have knowledge about the importance of VMMC but they are not circumcised and some participants have negative perceptions about VMMC while others had limited knowledge and misconceptions about circumcision. In addition, some men explained that they are not circumcised because they fear complications that may arise after the procedure while



others were advised by their sexual partners to be circumcised but still they have not undergone circumcision.

Based on the above model, there is a need to influence individual's perceptions on VMMC. Positive perceptions of men on VMMC in this study such "circumcision reduces the risk of HIV, STIs and chances of cervical cancer" need to be reinforced so that men can be motivated to undergo circumcision. This is true because evidence suggest that there is a clear relationship between male circumcision and disease prevention (Nevin et al 2015:10) and Gasasira et al (2012: Online). The negative perceptions which act as barriers that prevent men to be circumcised also need to be changed through continuous health education. These negative perceptions which need to be influenced include: first, the perception that HIV positive men are not supposed to be circumcised, and secondly, that circumcision is not associated with the elderly men and finally, that the foreskin protects the penis from cuts caused by pubic hair of women.

The model suggests that in order to ensure safe circumcision, men need to be made aware that safe circumcision services are only provided at a health facility. This will reduce the anxiety of some men who fear complications that may arise after the procedure. Lastly, the model recommends that there is a need to maintain a supportive social support system that will positively influence men to be circumcised. The study reveals that some men were advised to be circumcised by their sexual partners while others regard circumcision as a religious and traditional obligation. To ensure uptake of VMMC services, recommendations need to capitalize on utilizing that supportive social system to encourage men to be circumcised.

#### **4.6 CONCLUSION**

This chapter discussed research findings on men's perceptions on VMMC and literature control. The researcher conducted in-depth unstructured individual interviews and those interviews were audio recorded. The recorded interviews were later transcribed and data was coded.

The study revealed that uncircumcised Basotho men have different perceptions on VMMC. Themes that emerged included perceived health beliefs of men about circumcision. This is where participants believed that circumcision protects one from

diseases and improves personal hygiene. There are also sexual beliefs that were voiced out by the participants such as increased sexual pleasure.

The other theme that emerged was perceived community held beliefs about circumcision. Circumcision is regarded as passage to manhood and one is obliged by his religion to become circumcised even though he has not abided to that obligation. Various misconceptions about circumcision were also evident in this study. Men had various myths about circumcision and they have various attitudes towards circumcision. Lastly, there is knowledge gap in some other men as some participants voiced out that they cannot say much about circumcision as they do not know its importance.

Most of the findings of this study are similar to other studies that have been conducted by various researchers at different regions and contexts. Most of the studies reviewed link male circumcision with disease prevention and improved sexual pleasure, which are also evident in this study. On the other hand, there are some findings which are different from other studies. Some studies explain that men perceive circumcision as providing full protection from STIs while in this study men said that circumcision reduces chances of being infected with STIs and does not offer 100% protection. From the religious perspective, some studies reveal that men said that circumcision is against their Christian religion as removing the foreskin will be religiously abhorrent. In this study, men explained that they perceive circumcision as a religious obligation because the Bible allows men to be circumcised.

Chapter 5 concludes the study and discusses limitations for the study. Based on the findings of the study, the researcher makes recommendations for health care practice, policy formulation and research.

## **CHAPTER 5**

### **CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS**

#### **5.1 INTRODUCTION**

In chapter 4, the researcher described the research findings regarding men's perceptions of VMMC in Lesotho. In this chapter, the researcher presents the recommendations for the uptake of VMMC services at a hospital in Morija, Lesotho. In addition, the researcher concludes and discusses limitations for the study. Based on the findings of the study, the researcher makes recommendations for health care practice, policy formulation and research.

#### **5.2 CONCLUSIONS**

In this study, the researcher conducted a qualitative study, which studied observable facts in a holistic manner through collection of rich descriptive materials (Polit & Beck 2012:739). The research dealt with the exploration and description of perceptions of men regarding VMMC in a Hospital in Morija, Lesotho, with the aim of making relevant recommendations on how to promote the uptake of VMMC in the context of the study.

A qualitative research design that is explorative, descriptive and contextual in nature was used to gain insight on men's perceptions towards VMMC. Qualitative design was opted for because the researcher wanted to collect information on understanding of men on VMMC in a natural environment and not establishing cause-effect relationship. The design had to be explorative and descriptive because the researcher wanted to explore in-depth the perceptions of men on VMMC and later describe them. In addition, the design had to be contextualised because the researcher wanted to present the findings in the context of the population studied which is "uncircumcised men at a male clinic in a hospital in Morija Lesotho" (Creswell 2014:243). The research design that was utilized assisted the researcher to gain understanding of the perceptions of men regarding VMMC at a male clinic in a hospital in Morija Lesotho because men voiced out their different perceptions on circumcision and some perceptions act as barriers for those men to be

circumcised. The researcher also found this design to be relevant in helping him answer the main research question.

This design had some shortfalls as the results obtained from this study cannot be generalised due to the fact that small population was studied and qualitative studies do not pursue generalization (Polit & Beck 2012:15). In addition, the design did not allow the researcher to assess cause-effect relationship between some variables as some participants said that circumcision improves sexual pleasure and that needs to be tested or refuted.

Population in the study comprised uncircumcised men attending male clinic at a hospital in Morija, Lesotho. Brink et al (2012:131) define sampling criteria as attributes that participants have, that make them appropriate to be included or to be disqualified in a study and this included the following: (a) uncircumcised men attending males' clinic seeking other health services rather than VMMC, (b) Be above 18 years, (c) be willing to participate in the study, (d) be able to speak Sesotho or English and (d) be able to provide informed consent. Uncircumcised men attending males' clinic seeking other health services rather than VMMC had different perceptions on VMMC, thus purposive sampling technique was used.

Data was collected through in-depth face-to-face unstructured individual interviews and field notes. The in-depth face-to-face unstructured individual interviews assisted the researcher to collect qualitative data and the interviews gave participants chance to ask questions where they did not understand. In addition, the interviews allowed participants to tell their perceptions on VMMC with minimal interruptions and allowed the researcher to enquire more when there was need for clarity (Brink et al 2012:158). These interviews were demanding in terms of time. Recording of the interviews ensured that data is participants' actual verbatim responses and allowed the researcher to give the participants full attention during the interview. Recording of an interview also allowed the researcher not to misinterpret what the participants had said during data analysis (van Rensburg 2010:183).

Data analysis was conducted and results were compared with reviewed literature to determine knowledge gaps. This method of data analysis assisted the researcher to compare and contrast final data in order to determine themes that emerge (Brink et al

2012:122). Comparing the findings of the study with the literature assisted the researcher to support findings of the study and also to refute some of the findings.

Results presented in the previous chapter show that men have various perceptions of VMMC and some perceptions act as a barrier for them to be circumcised. Four main themes emerged which are: (1) perceived health beliefs of men about circumcision, (2) perceived community held beliefs about circumcision, (3) men's knowledge regarding circumcision, and (4) perceived misconceptions about circumcision. Most of the participants emphasized that circumcision protects one from diseases such as HIV and STIs but contrary to this fact, men still have fear of being circumcised.

Most of the findings of this study are similar to other studies that have been conducted by various researchers at different locations. Maibvise (2012:79), Nevin et al (2015:10) and Gasasira, et al (2012: Online) are of the view that male circumcision reduces chances of an individual to be infected with diseases and this is consistent with the findings of this study. Maibvise (2012:79) is quoted as follows in relation to disease prevention: "Almost all the participants acknowledged their understanding of the fact that circumcision in one way or other prevents the risk of acquiring certain diseases, as promoted in various media, thus constituting a major motive to be circumcised".

The findings of this study that link circumcision with improved sexual pleasure are also evident in the studies conducted by Maibvise et al (2017:3), Gao et al (2015:1), Maraoux et al (2017: Online) & Peltzer (2013:5417) who shares the same views that circumcision improves sexual pleasure. On the other hand, there are some findings which are different from other studies. Maibvise and Mavundla (2015:7) explain that some men perceive circumcision as providing 100% protection from STIs while in this study men said that circumcision reduces chances of being infected with STIs and does not offer 100% protection. In addition on the issue of religion, Maibvise and Mavundla (2014:283) explain that men in the study they conducted said that circumcision is against their Christian religion as removing the foreskin will be tempering with the temple of the Lord. On the other hand, men in this study explained that they perceive circumcision as a religious obligation because the Bible commands men to be circumcised.

Some of the findings in this study were not identified in other reviewed studies. This study revealed that men have perceived misconceptions that circumcision cannot be carried

out on a crooked penis and also on HIV positive men. The study generated new knowledge that some men perceive a foreskin as protecting the penis from cuts, which can be caused by pubic hairs of women.

Recommendations on promoting uptake of VMMC services were formulated by the researcher based on the results of the study. These recommendations are contextualized to the study population and area of the study and it is the duty of the users of the findings to assess whether the recommendations are applicable to their own context.

### **5.3 LIMITATIONS OF THE STUDY**

Polit and Beck (2012:65) are of the view that when a researcher discusses limitations in his study, this shows the readers of the research that the researcher was aware of these limitations and took them into consideration when interpreting the findings. Due to the above mentioned fact, the researcher considers the findings of this study to be credible and can be used by the scientific community. The researcher identified the following limitations:

- Quality of data collected from the participants may have been compromised by the fact that the researcher is a nurse and was on full nurse's uniform during data collection. Some participants might have not freely voiced out their perceptions because of fear of being interviewed by a nurse on health matters.
- Due to the sensitive nature of the topic of circumcision, some men may have not freely voiced out their perceptions on VMMC. This might have been because the researcher is also a registered nurse employed by the hospital where this study was conducted, thus compromising quality of data collected
- This study was qualitative in nature with limited number of participants. The aim of qualitative studies is not to generalise but to place the findings within the natural context of the phenomenon under investigation. Because of the contextual character of this study, the findings were not generalised but placed within a hospital settings in Lesotho. A thick description of the research process followed by the researcher has been provided in chapter three to allow those who would

like to conduct the same study a chance to do so following the process used by the researcher in this study.

## **5.4 RECOMMENDATIONS**

Based on the findings of this study, the researcher wishes to make the following recommendations for health care practice, education and research.

### **5.4.1 Recommendations for Health care practice**

In order to ensure that quality male circumcision services are provided to men and more men are motivated to be circumcised, the following recommendations are proposed: Men's knowledge need to be improved, their negative perceptions need to be changed, clients need to choose their preferred service providers, safe VMMC services must be easily accessible to all men and a multi-sectoral approach in influencing men to be circumcised must be instituted.

#### **5.4.1.1 Improving men's knowledge**

Most of the participants already have knowledge about the importance of VMMC but they are not circumcised. The following action is recommended:

As health education on various health issues is provided daily before the routine of the clinic, education circumcision must be provided on daily basis as a routine. This will address knowledge gap as some of the study participants showed that they have knowledge deficit on VMMC.

#### **5.4.1.2 Changing men's perceptions**

Some participants had negative perceptions about VMMC while others had limited knowledge. The following action is recommended:

During data collection in the private room, most of the men showed interest to be circumcised. On daily basis, men must be offered an opportunity to meet a health

care provider either a nurse or a counsellor in a private space to discuss the client's perceptions and fears on VMMC. This action will lead to correction of client's perceptions and eventually encourage them to be circumcised.

#### **5.4.1.3 Ensuring preferred health service provider**

In this study, some of the participants explained that they prefer to be circumcised by specific male nurses. This is because they want to utilise the nurse-patient relationship effectively. The following action is recommended:

Staffing pattern in male clinic must be tailored in a way that most of circumcising health care providers are male nurses or doctors and clients should be given preference to choose the health care provider they want. This will ensure that client-patient relationship is used as a pull factor to circumcision.

#### **5.4.1.4 Ensuring accessibility of VMMC services**

Some participants have misconceptions about VMMC which need to be corrected. These misconceptions act as barriers to VMMC uptake. The following action is recommended:

VMMC services should be made easily accessible to all men and this can be done by conducting outreach programs of circumcisions. During outreaches, men will be circumcised and also health messages related on circumcision will be passed through community gatherings.

#### **5.4.1.5 Safe male circumcision services**

In this study, some men explained that they are not circumcised because they fear complications that may arise after the procedure. Men need to be made aware that only safe male circumcision services are provided in the clinical setting. The following action is recommended:



Men need to be informed that complications associated with circumcision can only be prevented and managed in a clinical setting through use of scientifically tested methods. These messages can be passed through media and public gatherings.

#### **5.4.1.6 A multi-sectoral approach**

Some of the study participant's sexual partners advised them to be circumcised but those men are still not circumcised. A multi-sectoral approach is necessary to influence those uncircumcised to undergo the procedure. The following action is recommended:

Women also need to be included in VMMC issues especially at the community level. Existing women social groups in the communities need to be utilised to promote uptake of VMMC services. Messages regarding importance of circumcision need to be passed to these groups. These are the right people who can influence men (their partners) to be circumcised.

#### **5.4.1.7 Social support system**

Health care providers need to work hand in hand with men's social support system (relatives, spouses, community and spiritual leaders) to use men's positive perceptions to motivate men to be circumcised (Maibvise & Mavundla 2018:16). The following action is recommended:

Community leaders which include chiefs, priests, community counsellors and politicians need to be extensively trained on VMMC. When they are trained, they will be regarded as VMMC ambassadors. During any gathering hosted by the VMMC ambassadors, they must make sure that they pass VMMC specific messages and encourage men to be circumcised.

#### **5.4.2 Recommendation for education**

The following is recommended for education and training of nurses in Lesotho:

During the next review of the nursing education curriculum, issues relating to circumcision must be incorporated. Within the Medical and Surgical module,

indications of circumcision and its importance need to be included into the module. This will assist nursing students during community health outreaches to provide proper health education in relation to male circumcision.

#### 5.4.3 Recommendations for policy formulation

The following are recommended for policy formulation in Lesotho:

- Mass media campaigns on VMMC must be included in VMMC policy. This will counteract knowledge gap that was observed during data collection as some men have limited knowledge about importance of circumcision.
- Provision of incentives for men who have just undergone circumcision must be explored. The incentives can be in the form of Information, Education and Communication (IEC) materials such as T-shirts and bags. Other forms of incentives that can be considered can be food parcels and gifts. This can serve as a motivator for more men to be circumcised.
- There is a need to increase the number of male village health workers in the communities. This is done to offer uncircumcised men chance to communicate with immediate health care provider about circumcision issues freely.

#### 5.4.4 Recommendations research

For further research, the following are recommended:

- Because this study and other previously conducted studies explored the perceptions of men regarding male circumcision, there is a need for the development and testing of a **research tool** to be used in future quantitative survey studies.
- This study was qualitative in nature as a result the survey instrument referred to above will help sexual and reproductive health researchers to conduct a similar study on a larger sample of men in Lesotho and elsewhere in the world. A quantitative survey looking at the perceptions of uncircumcised men in Lesotho will help with the generalisability of findings to a broader sample of men. In

addition, for the next Lesotho demographic health survey (DHS) to be conducted, questions about perceptions of men on VMMC need to be included. This kind of survey will also help in assessing broader sample of men looking at their perceptions towards VMMC.

- In the context of Lesotho, more studies are needed to test interventions like models and guidelines to promote VMMC by looking at the cause and effect on the recipients. For instance, the model to promote the uptake of male circumcision used to guide this study may also be used to test its components including some of the recommendations made by the researcher in this study.

## **5.5 CONCLUDING REMARKS**

This chapter concluded this study, discussed limitations and recommendations for health care practice, policy formulation and research. The two objectives of the study which are exploration and description of perceptions of men regarding VMMC and making relevant recommendations on how to promote the uptake of VMMC seem to have been achieved. Uncircumcised men have different perceptions on circumcision and it was this for this study to find out such perceptions. The recommendations from this study can be used for health care practice, policy formulation and research so as uptake of VMMC services can be promoted.

## REFERENCES

Advocates for youth. 2007. Sexual development through the life cycle. From: <http://www.advocatesforyouth.org/publications/201-lessons> (Accessed 26 May 2018).

Brink, H, van der Walt, C and van Rensburg, G. 2012. *Fundamentals of research methodology for health care professionals*. 3<sup>rd</sup> edition. Cape Town: Juta and company.

Burns, N, Grove, SK & Gray, JR. 2013: *The practice of nursing research: Appraisal, synthesis and generation of evidence*. 7<sup>th</sup> edition. St Louis: Elsevier.

Christensen, MC, Krapf, S, Kempel, A & Heymann, CV. 2009. Cost of excessive postoperative haemorrhage in cardiac surgery. *Journal of Thoracic and Cardiovascular surgery*. 138 (3): 687-693.

Corduk, N, Unlu, G, Sarioglu-Buke, A, Buber, A, Savran, B & Zencir, M. 2013. Knowledge, Attitude and Behaviour of Boys and Parents about Circumcision. *Acta Paediatrica* (102):169-173.

Creswell, JW. 2014. *Research Designs: Qualitative, Quantitative and Mixed Methods Approaches*. SAGE: California.

Dunsmuir, WD & Gordon, EM. 1999. The History of Circumcision. *BJU International* 1(83): 1-12.

English Oxford dictionary. 2017. Clinic. Oxford. From <https://en.oxforddictionaries.com/definition/clinic> (Accessed 14 May 2017).

English Oxford dictionary. 2017. Knowledge. Oxford. From <https://en.oxforddictionaries.com/definition/knowledge> (Accessed 14 May 2017).

English Oxford dictionary. 2017. Perceptions. Oxford. From <https://en.oxforddictionaries.com/definition/perceptions> (Accessed 14 May 2017).

Fink, KS, Carson, CC & Devellis, RS. 2002. Adult circumcision outcomes study: Effects on erectile function, penile sensitivity, sexual activity and satisfaction. *Journal of urology*. 5 (167): 2112-2116.

Gasasira, RA, Saker, M, Tsague, L, Nsanzimana, S, Gwiza, A, Mbabazi, J, Karema, C, Asimwe, A & Mugweneza, P. 2012. Determinants of Circumcision and Willingness to be Circumcised by Rwandan Men, 2010. *BMC Public Health*. From: <http://www.biomedcentral.com/1471-2458/12/134> (Accessed 7 July 2017).

Gonzales, FA, Zea, MC, Reisen, CA, Bianchi, FT, Rodriguez, CFB, Pardo, MA & Poppen, PJ. 2012. Popular Perceptions of Circumcision among Colombian Men who have Sex with Men. *Routledge* 9 (14): 991-1005.

Henerey, A. 2004. Evolution of Male Circumcision as Normative Control. *The Journal of Men's Studies* 12 (3):265-276.

Howard-Payne, L & Bowman, B. 2017. "I am the Man": Meaning of Masculinity in Perceptions of Voluntary Medical Male Circumcision for HIV Prevention in South Africa. *American Psychological Association*. From: <http://dx.doi.org/10.1037/men0000039> (Accessed 7 July 2017).

Hussein, A. 2009. The use of Triangulation in Social Science Research: Can qualitative and quantitative methods be combined. *Journal of Comparative Social Work* (1): 1-12.

Ikwegbue, JN, Ross, A & Ogonnaya, H. 2015. Rural Zulu Women's Knowledge of and Attitudes towards Medical Male Circumcision. *Prm Health Care Fam Med* (1) 7: From: <http://dx.doi.org/10.4102/phcfm.v7i1.775> (Accessed 7 July 2017).

Ikwegbue, JN, Ross, A & Ogonnaya, H. 2015. Rural Zulu Women's Knowledge of and Attitudes towards Medical Male Circumcision. *Prm Health Care Fam Med* (1) 7: From: <http://dx.doi.org/10.4102/phcfm.v7i1.775> (Accessed 7 July 2017).

Imm, N.2015. Peyronie's disease. From: <https://patient.info/health/penis-problems/peyronies-disease> (Accessed 26 May 2018).

Jia, L, Hawley, SR & Zhang, X. 2014. Attitudes Towards Male Circumcision Among Chinese and its Implications. *Journal of Cultural Diversity* 4 (21):130-134.

Jones, D, Cook, R, Arheart, K, Redding, CA, Zulu, R, Castro, J & Weiss, SM. 2014. Acceptability, Knowledge, Beliefs and Partners as Determinants of Zambia Men's Readiness to Undergo Medical Male Circumcision. *AIDS Behaviour* (18): 278-284.

Joubert, G & Ehrlich, R. 2007. *Epidemiology: A research manual for South Africa*. Oxford University of Press. Cape Town.

Lesotho Ministry of Health. 2015. *FY 2015 Lesotho Country Operational Plan*. Maseru. Government printers.

Lesotho Ministry of Health. 2016a. National Guidelines on the Use of Antiretroviral Therapy for HIV Prevention and Treatment. Maseru. Government printers.

Lesotho Ministry of Health. 2016b. *Demographic and Health Survey 2014*. Maseru. Government printers.

Lesotho Nursing Council. 2016. Expanding Access to HIV & AIDS Prevention Services in Lesotho Through The Nurse-Midwife Led VMMC/EIMC Delivery Model: Report of Activities Accomplished as Part of the Pilot. Maseru: LNC.

Macintyre, K, Andrinopoulos, K, Moses, N, Borstein, M, Ochieng, A, Peacock, E & Bertrand, J. 2014. Attitudes, Perceptions and Potential uptake of Male Circumcision among Older Men in Turkana County, Kenya Using Qualitative Methods. *Plos One* (5) 9. From: [e83998.doi:10.1371/journal.pone.0083998](https://doi.org/10.1371/journal.pone.0083998) (Accessed 7 July 2017).

Maibvise, C & Mavundla, TR. 2018. A model to promote the uptake of male circumcision (MC) as an HIV preventive measure in high HIV and low MC prevalence setting. PHD thesis. UNISA. Pretoria.

Maibvise, C, Mavundla, TR & Nsibandze, BS. 2017. Psychological motives for undergoing medical circumcision (MC) in High HIV epidemic areas the probable impact

on the mass MC strategy of HIV prevention: A case study of Swaziland. *Journal of AIDS and Clinical Research* 4(8):2-6.

Maibvise, C & Mavundla, TR. 2015. Swazi Men's Perceptions of the Protective Effect of Male Circumcision & its implications for HIV Prevention Strategy. *Tanzania Journal of Health Research* 17(2):1-10.

Maibvise, C & Mavundla, TR. 2013. Medical reasons for performing adult male circumcision in Swaziland. *Africa Journal of Nursing & Midwifery* 15(1): 139-148.

Maibvise, C. 2012. *The motives behind Swazi men's increasing interest in circumcision*. MPH dissertation. Unisa. Pretoria.

Maraux, B, Lissouba, P, Rain-Taljaard, Taljaard, R, Bouscailou, DTJ, Lewis, D, Puren, A & Auvert, B. 2017. Women's knowledge and perceptions of male circumcision before and after its roll-out in the South African township of Orange Farm from community-based cross-sectional surveys. PLoS ONE 12 (3). From <https://doi.org/10.1371/journal.pone.0173595> (Accessed 7 July 2017).

Martin, CJH & Fleming, V. 2010. A 15 step model for writing a research proposal. *British Journal of Midwifery* 18 (12):791-798.

Mary, AO. 2011. Examining the development of sexual behaviour of adolescent males. *Journal of Adolescent Health* 46 (4):3-11.

Masombuka, J. 2013. *Children's addiction to the drug "nyaope" in Shoshanguve township: Parents' experiences and support needs*. MSW dissertation. Unisa. Pretoria.

Mavundla, TR, Netswera, FG, Bottoman, B & Toth, FT. 2009. Rationalization of Indigenous Male Circumcision as a Sacred Religious Custom: Health Beliefs of Xhosa Men in South Africa. *Journal of Transcultural Nursing* 20(4): 395-404.

Mavundla, TR, Netswera, FG, Toth, FT & Bottoman, B & Tenge, S. 2010. How Boys Become Dogs: Stigmatization and Marginalization of Uncircumcised Xhosa Males in East London, South Africa. Sage pub. From

[https://www.academia.edu/2513246/How\\_Boys\\_Become\\_Dogs\\_Stigmatization\\_and\\_Marginalization\\_of\\_Uninitiated\\_Xhosa\\_Males\\_in\\_East\\_London\\_South\\_Africa\\_Qualitative\\_Health\\_Research\\_xx\\_x\\_1-11?auto=download](https://www.academia.edu/2513246/How_Boys_Become_Dogs_Stigmatization_and_Marginalization_of_Uninitiated_Xhosa_Males_in_East_London_South_Africa_Qualitative_Health_Research_xx_x_1-11?auto=download) (Accessed 8 June 2017).

Mavundla, TR, Poggenpoel, M & Gmeiner, A. 2011. A Model of Facilitative Communication for Support of General Hospital Nurses Nursing Mentally Ill People. Part 2: Model Description and evaluation. *Pubmed* 24(1):15-21.

Mavundla, TR. 2010. Professional nurses' perceptions of nursing mentally ill people in a general hospital. *Journal of Advanced Nursing*. 32(6): 1569-1578.

McNamara, C. 2012. Useful communication skills-How to paraphrase and summaries. From <https://managementhelp.org/blogs/personal-and-professional-coaching/2012/01/26/useful-communications-skills-how-to-paraphrase-and-summarize/> (Accessed 28 January 2018).

Molapo, TJ. 1977. Initiation and Circumcision. From: <http://unesdoc.unesco.org/images/0002/000214/021419eb.pdf> (Accessed 7 July 2017).

Morbidity and Mortality weekly Report. 2013. Voluntary Medical Male Circumcision- Southern and Eastern Africa, 2010-2013. *MMWR* 62 (47):953-957.

Morris, BJ, Hankins, CA, Tobian, AAR, Krieger, JN & Klausner JD. 2014. Does Male Circumcision protect against Sexually Transmitted Infections? Arguments and Meta-Analyses to the Contrary Fail to Withstand Scrutiny. *Hindawi*. From <http://dx.doi.org/10.1155/2014/684706> (Accessed 15 March 2017).

Mugwanya, KK, Baeten, JM, Nakku-Joloba, E, Katabira, E, Celum, C, Tisch, D & Whalen, C. 2010. Knowledge and Attitudes About Male Circumcision for HIV-1 Prevention among Heterosexual HIV-1 Serodiscordant Partnerships in Kampala, Uganda. *AIDS Behaviour* (14): 1190-1197.

Murtaza, A. 2015. What is smegma? A guide to the unappetizing biofluid that is smegma. From: <https://myheart.net/articles/smegma/> (Accessed 26 May 2018).



Naidoo, PV, Dawood, F, Driver, C, Narainsamy, M, Ndlovu, S & Ndlovu, V. 2012. Knowledge, Attitudes and Perceptions of Pharmacy and Nursing Students Towards Male Circumcision and HIV in a KwaZulu-Natal University, South Africa. *Prm Health Care Fam Med* 4 (1). From: <http://dx.doi.org/10.4102/phcfm.v4i1.327> (Accessed 7 July 2017).

Nevin, PE, Pfeiffer, J, Kibira, SPS, Lubinga, SJ, Mukose, A & Babigumira, JB. Perceptions of HIV and Safe Male Circumcision in High Prevalence Fishing Communities on Lake Victoria, Uganda. *Plos One* 10 (12).

NHS. 2018. Cervical cancer. From: <https://www.nhs.uk/conditions/cervical-cancer/causes> (Accessed 26 May 2018).

Nursing Theories. 2012. Dorothea Orem's self care theory. From: [http://currentnursing.com/nursing\\_theory/self\\_care\\_deficit\\_theory.html](http://currentnursing.com/nursing_theory/self_care_deficit_theory.html) (Accessed 26 May 2018).

Old Testament. 2011. The Bible. Bible Society of Lesotho: Maseru.

Peltzer, K. 2013. Knowledge, Attitudes, and Acceptance of Male Circumcision among HIV Lay Counsellors in Nkangala District, South Africa. *Gender and Behaviour* 11 (2): 5412-5430.

PEPFAR. See President's Emergency For AIDS Relief.

President's Emergency For AIDS Relief. 2011. Voluntary Medical Male Circumcision for HIV Prevention. The Cost, Impact and Challenges of Accelerated Scale-up in Southern and East Africa. *Plos Medicine*. From [www.ploscollections.org/vmmc2011](http://www.ploscollections.org/vmmc2011) (accessed 10 April 2017).

Polit, DF & Beck, CT. 2012. *Nursing Research: Generating and assessing evidence for nursing practice*. Philadelphia: Lippincott.

Public eye. 2017. Herd boys risk losing their jobs for the cut. 28 July-03 August 2017.

Shenton, AK. 2004. Strategies for ensuring trustworthiness in qualitative research projects. *Education for information* 22: 63-75.

Skills you need. 2018. Questioning techniques. From <https://www.skillsyouneed.com/ips/questioning.html> (Accessed 28 January 2018).

Skills you need. 2018. Reflecting. From <https://www.skillsyouneed.com/ips/reflecting.html> (Accessed 28 January 2018).

Skolnik, L, Tsui, S, Ashengo, AD, Kikaya, V & Lukobo-Durrell, M. 2014. A cross-sectional study describing motivation and barriers to voluntary medical male circumcision in Lesotho. *BMC Public Health* 14 (1119):14712458.

Streubert, HJ & Carpenter, DR. 2011. Qualitative research in nursing: Advancing the humanistic imperative. 5<sup>th</sup> ed. Philadelphia: Lippincott.

Thin, K & Remmelzwaal, B. 2012. *Guidelines for Conducting Operational Research. Lesotho Public health Sector*. Maseru. Government printers.

Tilly, A, Gurman, P, Dhillon, P, Jessica, L, Greene, Makadzange, Khumlao, P & Shekhar, N. 2015. Informing the scaling up of voluntary medical male circumcision efforts through the use of theory of reasoned action: Survey findings among uncircumcised young men in Swaziland. *AIDS free Education and Prevention* 27 (2): 153-166.

UNAIDS. See United Nation Program on HIV/AIDS.

United Nation Program on HIV/AIDS.. 2016. Global AIDS Update 2016. UNAIDS: Geneva.

University of Southern California. 2018. Organizing your social science research paper: Writing field notes. From <http://libguides.usc.edu/writingguide/fieldnotes> (Accessed 28 January 2018).

Van Dyk, A. 2012. *HIV and AIDS Education, Care and Counseling: A multidisciplinary approach*. 5<sup>th</sup> edition. Cape Town: Pearson.

Van Rensburg, GH. 2010. *Research in the Social Sciences. Only study guide for RSC2601*. Pretoria: Unisa.

Walls, AF. Moshoeshoe 1786 to 1870 Independent Lesotho. Dictionary of African Christian Biography. From [www.dacb.org/stories/lesotho/moshoeshoe.html](http://www.dacb.org/stories/lesotho/moshoeshoe.html) (Accessed 29 April 2017).

Weissman, A. 2014. Planning Contextual Research: What Clients need to Know. Effective. From <http://www.effectiveui.com/blog/2014/08/22/planning-contextual-research-what-clients-need-to-know> (Accessed 29 April 2017).

WHO. See World Health Organisation.

World Health Organisation. 2007. *Male Circumcision: Global Trends and Determinates of Prevalence, Safety and Acceptability*. WHO: Geneva.

World Health Organisation. 2012. Voluntary medical male circumcision for HIV prevention. From [http://www.who.int/hiv/topics/malecircumcision/fact\\_sheet/en](http://www.who.int/hiv/topics/malecircumcision/fact_sheet/en) (Accessed 29 April 2017).

World Health Organisation. 2015. Ministry of Health commences Voluntary Male Medical Circumcision services scaling up to tackle the HIV epidemic in Lesotho. From <http://www.afro.who.int/en/lesotho/press-materials/item/4874-ministry-of-health-commences-voluntary-male-medical-circumcision-services-scaling-up-to-tackle-the-hiv-epidemic-in-lesotho.html> (Accessed 10 October 2016).

Wilcken, A, Keil, T & Dick, B. 2010. Traditional male circumcision in eastern and southern Africa: A systematic review of prevalence and complications. WHO. From <http://www.who.int/bulletin/volumes/88/12/09-072975/en/> (Accessed 2 June 2017).

Yang, MH, Tsao, CW, Wu, ST, Chuang, FP, Meng, E, Tang, SH, Sun, GH, Yo, DS, Chang, SY and Cha, TL. 2013. The effects of circumcision on young adult sexual function. *Kaohsiung journal of medical sciences*. (2014) 30: 305-309.

**RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES**

**REC-012714-039 (NHERC)**

1 November 2017

Dear Mr Pule Solomon Moabi

**Decision: Ethics Approval**

**HSHDC/756/2017**

Mr Pule Solomon Moabi

Student No 51039702

Supervisor: -Prof TR Mavundla

Qualification: PhD

Joint Supervisor: -

**Name:** Mr Pule Solomon Moabi

**Proposal** Men's Perception regarding voluntary circumcision at a male clinic, Lesotho

**Qualification:** MPCHS94

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted from 1 November 2017 to 1 November 2019.

*The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on 2 August 2017.*

*The proposed research may now commence with the proviso that:*

- 1) The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*
- 2) Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*
- 3) The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*



4) [Stipulate any reporting requirements if applicable].

**Note:**

*The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.*

Kind regards,



Prof JE Maritz  
CHAIRPERSON  
[maritje@unisa.ac.za](mailto:maritje@unisa.ac.za)



Prof MM Moleki  
ACADEMIC CHAIRPERSON  
[molekmm@unisa.ac.za](mailto:molekmm@unisa.ac.za)



Prof A Phillips  
DEAN COLLEGE OF HUMAN SCIENCES



University of South Africa  
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**ANNEXTURE B: REQUEST LETTER TO MINISTRY OF HEALTH**

Pule Solomon Moabi  
P.O. Box 26  
Morija 190  
Cell: +266 58417220  
Email: pulemoabi@gmail.com

02 November 2017

The Chairperson  
Research Coordinating Unit  
Ministry of Health  
Maseru, Lesotho

Dear Sir/Madam

**RE: REQUEST TO CONDUCT A RESEARCH STUDY**

My name is Pule Solomon Moabi, a Clinical Tutor at Scott College of Nursing and currently registered for Masters in Public Health with University of South Africa (UNISA). I am engaged in a research project **“Men’s perception regarding voluntary circumcision at a male clinic, Lesotho”**.

As a requirement for attainment of my qualification, I am asking for clearance to conduct the above mentioned study and interview clients visiting males’ clinic at Scott Hospital Morija. Study participants will be protected by ensuring anonymity and those who do not want to participate will not be threatened. Study results may benefit the country on ways to increase turn-up of males to be circumcised and this will assist the country in reduction of new HIV infections. Expected research commencement and ending dates is from 1<sup>st</sup> to 29<sup>th</sup> December 2017.

I hope my request will be taken into consideration.

Yours Faithfully  
Pule Solomon Moabi



Researcher  
Registered Nurse Midwife, Clinical Tutor, BA Cur and Pg Diploma (UNISA)  
Supervisor  
Prof TR Mavundla

Registered Nurse Midwife, B Cur, M Cur, AUDNE and PHD

## ANNEXTURE C: APPROVAL FROM MINISTRY OF HEALTH



Ministry of Health  
PO Box 514  
Maseru 100

REF: ID129-2017

Date: 12 December 2017

To  
**Pule Solomon Moabi**  
MPH candidate, UNISA

**Category of Review:**

- ☒ Initial Review
- ☐ Continuing Annual Review
- ☐ Amendment/Modification
- ☐ Reactivation
- ☐ Serious Adverse Event
- ☐ Other \_\_\_\_\_

Dear P.S. Moabi,

**RE: Men's perception regarding voluntary circumcision at a male clinic, Lesotho**

This is to inform you that on 8 December 2017 the Ministry of Health Research and Ethics Committee reviewed and **APPROVED** the above protocol and hereby authorizes you to continue the study according to the activities and population specified in the protocol. Departure from the approved protocol will constitute a breach of this permission.

This approval includes review of the following attachments:

- ☒ Protocol Version 3.0, dated 02 November 2017
  - ☒ English & Sesotho consent forms
  - ☐ Question guide in English & Sesotho
  - ☐ Data collection tools in English version 3.0, dated 5 October 2017
  - ☐ Participant materials *[insert types, versions, dates]*
  - ☒ Other materials: The CV of the PI and letter of support from UNISA dated 7 November 2017
- This approval is **VALID** until 11 December 2018.

All serious adverse events associated with this study must be reported promptly to the MOH Research and Ethics Committee. Any modifications to the approved protocol or consent forms must be submitted to the committee prior to implementation of any changes.

We look forward to receiving your progress reports and a final report at the end of the study. If you have any questions, please contact the Research and Ethics Committee at [rcumoh@gmail.com](mailto:rcumoh@gmail.com) (or) 22226317.

Sincerely,

**Dr. Nyane Letsie**  
Director General Health Services

**Dr. Amelia Ranotsi**  
Chairperson NH-IRB



**ANNEXTURE D: LETTER OF REQUEST TO SCOTT  
HOSPITAL**

Pule Solomon Moabi  
P.O. Box 26  
Morija 190

02 November 2017

The Medical Superintendent  
Scott Hospital  
Private Bag  
Morija 190

Dear Sir

**RE: REQUEST TO CONDUCT A RESEARCH STUDY AT SCOTT HOSPITAL MALE CLINIC**

My name is Pule Solomon Moabi, a Clinical Tutor at Scott College of Nursing and currently registered for Masters in Public Health with University of South Africa (UNISA). I am engaged in a research project **“Men’s perception regarding voluntary circumcision at a male clinic, Lesotho”**.

As a requirement to complete my studies, I am requesting permission to interview clients visiting males’ clinic seeking other services other than circumcision. Study participants will be protected by ensuring anonymity and those who do not want to participate will not be threatened. Study results may assist the institution on ways to increase turn-up of males to be circumcised.

I hope my request will be taken into consideration.

Yours Faithfully

Pule Solomon Moabi



Researcher

Registered Nurse Midwife, Clinical Tutor, BA Cur and Pg Diploma (UNISA)

Supervisor

Prof TR Mavundla

Registered Nurse Midwife, B Cur, M Cur, AUDNE and PHD

## ANNEXTURE E: PERMISSION FROM SCOTT HOSPITAL



Comprehensive Health Care  
Phone: 22360000/22360237  
Fax: 22360237  
E-mail: scotthospital@ilesotho.com

# SCOTT HOSPITAL

of the  
Lesotho Evangelical Church



Private Bag  
Moriya, 190  
Lesotho

28 December 2017

Pule Solomon Moabi  
P.O. Box 26  
Moriya 190  
Lesotho

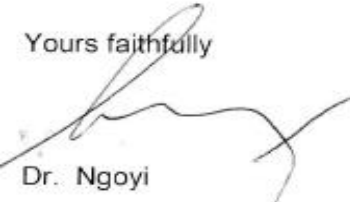
Dear Sir

### RE: PERMISSION TO CONDUCT RESEARCH AT SCOTT HOSPITAL

We have received your application dated 02 November 2017 requesting permission to undertake research at our hospital on **"Men's perception regarding voluntary circumcision at a male clinic, Lesotho"**.

I am glad to inform you that your request has been approved and you are allowed to conduct your study. Kindly comply with ethical rules on patient's confidentiality at all times. We are hoping to receive a final copy of the research report and we wish you success in your studies.

Yours faithfully

  
Dr. Ngoyi  
Medical Superintendent



## ANNEXTURE F: DEMOGRAPHIC DATA AND THE CENTRAL QUESTION

### **Demographic data**

1. Participant code\_\_\_\_\_

2. Age\_\_\_\_\_

3. Marital status (Tick that is applicable)

- ☐ Single [ ]
- ☐ Married [ ]
- ☐ Divorced [ ]
- ☐ Widowed [ ]

4. Religion (Tick that is applicable)

- ☐ Christian [ ]
- ☐ Islam [ ]
- ☐ Judaism [ ]
- ☐ Other (specify) [ ] \_\_\_\_\_

5. Residence (Tick that is applicable)

- ☐ Urban [ ]
- ☐ Rural [ ]
- ☐ Semi-urban [ ]

6. Level of education (Tick that is applicable)

- ☐ None [ ]
- ☐ Primary [ ]
- ☐ Secondary [ ]
- ☐ Tertiary [ ]

7. Employment status (Tick that is applicable)

- ☐ Unemployed [ ]
- ☐ Employed [ ]
- ☐ Self employed [ ]

### **The central question**

What is your understanding regarding voluntary circumcision?

## ANNEXTURE G: LITABA TSA EA NKANG KAROLO (DEMOGRAPHIC DATA AND THE CENTRAL QUESTION)

1. Nomoro ea motho ea nkang karolo\_\_\_\_\_
2. Lilemo\_\_\_\_\_
3. Litaba tsa lenyalo (khetha e nepahetseng)
  - Ha ke so nyale [ ]
  - Ke nyetse [ ]
  - Re hlalane [ ]
  - Ke mohlolo [ ]
4. Tumelo (khetha e nepahetseng)
  - Mokereste [ ]
  - Molsilamo [ ]
  - Mojuta [ ]
  - E ngoe (hlalosa) \_\_\_\_\_ [ ]
5. Bolulo (khetha e nepahetseng)
  - Mabalane [ ]
  - Mahaeeng [ ]
  - Seka-mabalane [ ]
6. Litaba tsa thuto (khetha e nepahetseng)
  - Ha kea kena sekolo [ ]
  - Sekolo sa mathomo [ ]
  - Sekolo se bohareng [ ]
  - Boemo bo ka holimo ho sekolo se phahameng [ ]
7. Litaba tsa ts'ebetso (khetha e nepahetseng)
  - Ha ke sebetse [ ]
  - Kea sebetsa, ke hiruo [ ]
  - Kea its'ebetsa [ ]

### Potso ea Mantlha

Maikutlo a hau ke a feng malebana le ho rola katiba?

## ANNEXTURE H: CONSENT FORM

Pule Solomon Moabi  
P.O. Box 26  
Morija 190

02 November 2017

Dear Sir

### REQUEST FOR CONSENT TO PARTICIPATE IN A RESEARCH STUDY

My name is Pule Solomon Moabi, a Clinical Tutor at Scott College of Nursing and currently registered for Masters in Public Health with University of South Africa (UNISA). I am engaged in a research project **“Men’s perception regarding voluntary circumcision at a male clinic, Lesotho”**.

The purpose of the study is to determine men’s perceptions towards VMMC. Data will be collected in a form of interview which will be audio tapped for verification of findings. Interview is scheduled to take 35 to 45 minutes and all information provided and tapped will not be shared with people who are not directly involved in the study. Your identity will not be revealed during dissemination of report and you have a right to decline your participation at any stage without any penalty.

The benefit that you are likely to gain from participation in this study is that you will have a chance to express your perceptions on voluntary medical male circumcision. Those who will not participate may benefit by being circumcised as motives towards circumcision will have been explored. There are no incentives for participating in this study and should you wish to contact the researcher for any additional information that you think you left out during the interview, please feel free to contact him on (+266) 58417220.

Thank you for your participation

\_\_\_\_\_  
Participants’ signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Researchers’ signature

\_\_\_\_\_  
Date

**ANNEXTURE I: TUMELLANO EA HO NKA  
KAROLO (CONSENT FORM)**

Pule Solomon Moabi  
P.O. Box 26  
Morija 190

01 February 2018

Monghali

**KOPO EA HO NKA KAROLO LIPHUPUTSONG**

Lebitso la ka ke Pule Solomon Moabi, morupelli sekolong sa baoki Scott ea ntseng a ithutela tsa bophelo ba sechaba Junivesithing ea Afrika Boroa (UNISA). Ke ntse ke etsa liphuputso ka **“Maikutlo a banna ka ho rola katiba sepetleleng sa Scott, Lesotho”**.

Sepheo sa liphuputso tsena ke ho utloisisa maikutlo a banna ka ho rola katiba. Lipuisano li tla hatisoa ‘me puisano e tla nka metsotso e mashome a mararo ho isa metsotsong e mashome a mane a metso e mehlano. Litaba tse buoeng mono li tla bolokoa ele lekunutu ‘me mabitso a hau a ke ke a tsebisoa batho. U na le tokelo ea ho tsoa liphuputsong tsena neng kapa neng ha u se u sa batle.

U ke ke oa pataloa ha u nka karolo liphuputsong tsena, ha e ba u batla ho bua le mofuputsi ka linthla tseo u li lebetseng tsa puisano, u ka mo fumana nomorong ea (+266) 58417220.

Ke lebohela ho nka karolo hoa hau

\_\_\_\_\_  
Ea nkang karolo

\_\_\_\_\_  
Letsatsi

\_\_\_\_\_  
Mofuputsi

\_\_\_\_\_  
Letsatsi

## ANNEXTURE J: INTERVIEW TRASCRIPT

**Study:** Men's perception regarding voluntary circumcision at a male clinic, Lesotho

**Interviewer:** Pule Solomon Moabi

**Interviewee participant code:** 9

**Date:** 16/05/2018

**Duration:** 53 minutes and 47 seconds

**Place of interview:** Male clinic, Scott hospital

**Interviewer:** It has [voice recorder] started recording to avoid me disrupting the interview with writing. Today I am going to call you **Mr. Nine**

**Interviewee:** Ok, Thank you

**Interviewer:** How old are you Mr. 9?

**Interviewee:** I am 29 years old

**Interviewer:** Are you married?

**Interviewee:** No I am not married

**Interviewer:** You are not married?

**Interviewee:** Yes

**Interviewer:** What is your religion?

**Interviewee:** You mean church?

**Interviewer:** Yes

**Interviewee:** I am a Roman Catholic

**Interviewer:** So the Roman Catholics are Christians?

**Interviewee:** Yes they are

**Interviewer:** Ok. Where do you stay?

**Interviewee:** Em. I Live at Ha Matala but I originate from Koro-koro

**Interviewer:** Does that mean you are from the urban area?

**Interviewee:** Yes I am

**Interviewer:** What is you highest educational status?

**Interviewee:** I dropped school at Form C

**Interviewer:** So your highest educational status is secondary?

**Interviewee:** Yes

**Interviewer:** What is your occupation status?

**Interviewee:** I am employed

**Interviewer:** Ok, Are you seated comfortable there?

**Interviewee:** Yes I am

**Interviewer:** Today's main agenda is on your views and perceptions on voluntary circumcision? What is your take?

**Interviewee:** Yes, you know this thing when I started to hear about it, I heard that it is not that important to men

**Interviewer:** Yes.

**Interviewee:** According to what was said during those times, we were wondering about its side effects. What will to me happen after some years when I have done circumcision? What are the side effects when I am old? What scared me is there was no one who knew about side effects of circumcision. Earlier it was not known that there will be HIV infection, so when someone has removed his foreskin and other diseases emerge, there will no longer be a foreskin to protect the penis. That was the main concern.

**Interviewer:** So which are the side effects of circumcision that you thought about?

**Interviewee:** It was that if a new disease emerges and I do sex with a woman and the penis is naked without the foreskin, what will happen to me? Again, these condoms we use have some kind of lubricant that we do not know its origin. So during sex, this lubricant comes in contact with circumcised "naked penis" which may even cause other diseases and this was my main concern. These days I have seen that my colleagues are circumcised and after sex, when he has removes the condom, his penis will be dry but to mine will be wet and the foreskin covers that dampness. Then he will say that my foreskin is going to harbour some illnesses that are going to make my penis sick.

**Interviewer:** Are you referring to some infections that you may have contracted from your partner?

**Interviewee:** Yes

**Interviewer:** Earlier you thought the foreskin was protecting the urethral meatus from some infections

**Interviewee:** Yes, from some infections

**Interviewer:** Ok

**Interviewee:** It is said that circumcised men cannot have [*unclear words*]. Some people think that if they are circumcised, they cannot use condoms during sex. During sex, the pubic hair of women can cause some cuts on the penis, so circumcised penis can ulcerate due to lack of protection from the foreskin



**Interviewer:** Are you saying that the foreskin could have protected the penis from the cuts?

**Interviewee:** Yes, it could have protected the penis from the cuts

**Interviewer:** Ok, I hear what you have said about the foreskin. So what prevented you from being circumcised is that you thought that the foreskin protects the penis from cuts?

**Interviewee:** Yes

**Interviewer:** How is the interaction between you and other men when you talk about circumcision?

**Interviewee:** Each man argues for his side. Circumcised men argued that they are protected and I also say that I am also protected. I told them that the penis is left unprotected hence vulnerable. They said that my foreskin is the one that is going to cause me diseases. At the end they say I might be correct, because pubic hair of women can cause cuts to the penis during unprotected sexual intercourse. So myself I am protected by the foreskin. But then they say when the foreskin goes back to its original position, the penis harbours some disease.

**Interviewer:** So uncircumcised men cannot use condoms because they are protected?

**Interviewee:** Yes, that is the belief. It reduces chances of being infected.

**Interviewer:** What does this mean? A man is still at risk of being infected with other diseases?

**Interviewee:** Yes

**Interviewer:** Which ones?

**Interviewee:** Sexually transmitted diseases and vaginal discharge from women

**Interviewer:** Is sexual activity pleasure similar on circumcised and uncircumcised men?

**Interviewee:** I heard it from women because my girlfriend says I must get circumcised. Then I asked her whether she had sex with someone who is circumcised and noted the difference between sexual pleasures. She said she has no experience and she will be shy to talk. But people say there is more pleasure when one is circumcised and most of them do unprotected sexual intercourse

**Interviewer:** Oh.

**Interviewee:** They say it is so nice and there is no need to use condoms

**Interviewer:** I hear what you have said, any other views?

**Interviewee:** I just want you to explain to me the side effects of circumcision, how long will I be completely healed? This is because I work at Bloemfontein and I have to departure on Friday.

**Interviewer:** The foreskin can easily get lesions due to its dampness and some microbes get easy access through the foreskin. If the foreskin is removed, the glans penis is tough and no microbes can get easy access. How do they remove this foreskin?

**Interviewee:** I heard from a circumcised guy that he was put a peg on the penis which leads to the fall of the foreskin. I am thinking whether they use knives or scissors to remove the foreskin (*straight face*).

**Interviewer:** When you talk about knife and scissors, do you fear pain?

**Interviewee:** (*smiles and laughs*) Too much, I am scared of pain.

**Interviewer:** I hear what you have said.

**Interviewee:** They say that during the time of dressing the wound, they remove the dressing roughly causing pain and bleeding leading to delayed wound healing. I want to be circumcised but it is a bit late because I have to get back to work. Next time when I come home I will get circumcised. Is that not painful? Last time when I came for consultation, I saw some small kids crying after they were circumcised. I wondered if this circumcision really causes that much pain because I cannot deal with pain.

**Interviewer:** I see you have fear of pain.

**Interviewee:** Yes.

**Interviewer:** Why did those children cry?

**Interviewee:** Is because the pain injection has worn off? Then I was scared and took conclusion that this procedure is painful. I actually came for circumcision that day, but then I decided to go home because of those children who were crying of pain.

**Interviewer:** Oh, you came and there after you saw those children crying you decided not to be circumcised?

**Interviewee:** Yes, I did not want people to laugh at me when I am in pain. But now if I was working near home, I would get circumcised because family and friends would look after me.

**Interviewer:** So when you have time, you will come here?

**Interviewee:** Yes, I will be on two weeks leave in September.

**Interviewer:** So you will get back to work completely healed. Your main fear is pain, right?

**Interviewee:** Yes. I have this bad experience. I went to consult at Roma hospital and I was given an injection. I was injected at the bone not the buttocks and I took 2-3 months with weak leg and the injection side was also swollen. That is what made me to be scared of circumcision, incompetent people during injection.

**Interviewer:** Are you saying that you need a health care service provider who is competent on what he/she is doing?

**Interviewee:** Yes, that is what scared me most. After that time, I refused to be injected as I opted for oral medications.

**Interviewer:** Have you meet people or friends who had delayed wound healing?

**Interviewee:** No, but they say when the dressings on the penis are removed, those people who remove the dressings are very rough and they also apply methylated spirit on the wound.

**Interviewer:** Oh!

**Interviewee:** Methylated spirit on the wound! I decided not to be circumcised then because not all men in Lesotho are circumcised.

**Interviewer:** I hope you will have time to reflect and think of what you want in relation to circumcision.

**Interviewee:** Yes I will because I need good health and I have just tested HIV negative. I do not want to be infected by HIV because I have not been circumcised.

**Interviewee:** *Talks about his unfaithful girlfriend for 22 minutes.....*

**Interviewer:** Thank you very much for talking to me let me switch this thing off [voice recorder]